Arizona Medical Board

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FINAL MINUTES FOR REGULAR SESSION MEETING
Held on August 8, 2007 and August 9, 2007
9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

William R. Martin III, M.D., Chair
Douglas D. Lee, M.D., Vice Chair
Dona Pardo, Ph.D., R.N., Secretary
Dan Eckstrom
Robert P. Goldfarb, M.D., F.A.C.S.
Patricia R. J. Griffen
Ram R. Krishna, M.D.
Todd A. Lefkowitz, M.D.
Lorraine L. Mackstaller, M.D.
Paul M. Petelin Sr., M.D.
Germaine Proulx
Amy J. Schneider, M.D., F.A.C.O.G.

Call to Order

The meeting was called to order at 9:30 a.m.

Roll Call

The following Board members were present: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.

Call to Public

Statements issued during the Call to Public appear beneath the case referenced.

Executive Director's Report

Agency Office Report

Timothy Miller, J.D., Executive Director provided an update on the progress of the new database. The Agency anticipated online renewals and online applications once the new database had been implemented by an outside vendor; however, the outside vendor will no longer promise to do this. The Agency's vendor is capable of implementing online renewals and online applications; however, the Agency did not budget for this expenditure and will adjust its next fiscal year's budget to use the vendor's on-line renewal and application software.

Mr. Miller presented the Fiscal Year-end reports to the Board. He highlighted that currently it takes 24 days to complete the Agency's portion of the licensing process, which has decreased by 12 days from last year. He noted that 86% of applications are deficient and are sent back to the applicant, which puts the process on hold until the application is corrected and returned to the Agency. Applicants take an average of 63 days to resubmit their corrected applications. On average, it takes 87 days to complete the application process, which is still very good when compared to other states. Mr. Miller stated when the Agency implements online renewals and applications; this will decrease the number of deficient applications. He informed the Board that the Agency's Case Management Office has been doing spectacularly well with only four percent of open investigations that are 180 days old, which represents a 19% decrease from last year.

Mr. Miller reported that during the past two months he has been responding to questions regarding physicians' scope of practice and office based surgery procedures. Questions have included how physicians are allowed to practice in Arizona without an Allopathic License as Naturopathic and Homeopathic physicians. He stated these issues have stemmed from recent cases before the Board.

Approval of 2008 Meeting Dates

Mr. Miller requested approval of the 2008 Board Meeting schedule.

MOTION: Dr. Lee moved to accept the 2008 Meeting Dates.
SECONDED: Ms. Proulx
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

FY 2006-2007 Annual Report

Mr. Miller provided an overview of the FY 2006-2007 Annual Report that included updates on the Board's activities and accomplishments for the year. Mr. Miller stated that the Board plans to be outreach oriented now that the Agency is running smoothly.

MOTION: Ms. Proulx moved to accept the FY 2006-2007 Annual Report.
SECONDED: Ms. Griffen
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

Dr. Goldfarb noted that each time the number of licensed physicians in Arizona is calculated, it is important to specify how many are actually practicing in the State. He stated there seems to be more licensed physicians this year than last year and questioned how many are practicing here. Mr. Miller stated the Agency is in the process of narrowing down the number, per a request from the Governor's Office, but this has been difficult with the Agency's current database.

FY 2008-2010 Strategic Plan

Mr. Miller requested the Board approve the FY 2008-2010 Strategic Plan. The Strategic Plan demonstrates the agency's performance measures for 2007, the expected performance for 2008, and the projected performance for 2009-2010. Mr. Miller also informed the Board that the word "education" had been added to the Board's mission statement. He stated that most of the items in the Strategic Plan have to do with outreach and education for physicians. He also stated that compared to other states, the Board does not have a true Physician Health Program (PHP) and he is hopeful that a PHP can be developed and noted a statutory change would be required. In addition, he announced the Board will no longer hold One Day Meetings, as there is no longer a backlog of cases pending formal interviews.

MOTION: Ms. Griffen moved to accept the FY 2008-2010 Strategic Plan.
SECONDED: Ms. Proulx
VOICE VOTE
VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 4-absent.
MOTION PASSED.

Approval of Offsite Meeting Agenda

Dr. Martin requested the Board review the discussion items for the Offsite Meeting Agenda. Mr. Miller stated that the Federation of State Medical Boards (FSMB) will present an update on their process and procedures and he requested additional topics from the Board. Dr. Martin requested FSMB also provide an update on portability of licenses. Dr. Petelin requested Board discussion regarding the Mayo Clinic malpractice settlements. Dr. Petelin noted that it is a statutory requirement to report malpractice cases regarding physicians licensed by the Arizona Medical Board; however, Mayo Clinic physicians are not being reported to the to the Board or the National Practitioner's Databank (NPDB). Mr. Miller stated that earlier this year letters were sent to all hospital directors reminding them of their duty to report; however, the directors insist that only the suspension of a physician's privileges apply to this requirement. Mr. Miller also stated that the Board reports hospitals to the Department of Health Services (DHS) when they do not follow the reporting requirement. The Board agreed to add this issue to the Offsite Meeting Agenda. Dr. Goldfarb requested the physicians' scope of practice be a high priority discussion topic. The Board also agreed to place Committee updates as a priority discussion item. Mr. Miller stated he would like to update the Board on the Attorney General (AG) legal affairs at the Offsite Meeting, as it is an important issue. In addition, it was determined that a discussion regarding the Physician's Health Program would be included if the Board had time.

Christine Cassetta, Board Legal Counsel, noted that previously, the Board adopted a standard of care in regard to ophthalmology and this was no longer an open issue and did not need to be on the Offsite Meeting agenda. Dr. Martin stated that the Board's Guidelines Subcommittee should be dealing with this issue and it did not need to be placed on the agenda. Patient care in the prison system and process for filing complaints were noted to be important issues, but will not be priority topics. The Board agreed to remove the discussion regarding abortions and hospital privileges, as Mr. Miller stated this is not a Board issue and is addressed by DHS.

Chair's Report

Discussion of Physician's Scope of Practice

Dr. Martin asked the Board to place this topic on their Offsite Meeting agenda for further discussion. Dr. Petelin asked if the Board would also add discussion with the FSMB to inform the Board on how other State Medical Boards are handling this issue. The Board noted there are a number of physicians performing cosmetic surgery without having the proper training. Mr. Miller stated he will query other state medical board directors to see how they deal with this issue.

Legal Advisor Report

2007 Statutory Amendments

Ms. Cassetta updated the Board on recent statutory amendments. The Board has previously been given authority to order non-disciplinary CME, but this year the Legislature simplified the language. She has also reviewed the bill involving emergency room personnel and how they would be required to cooperate with law enforcement in cases involving questions about a patient's blood alcohol concentration. Ms. Cassetta informed the Board of the Board of Pharmacy statute regarding the prescription monitoring program. Although the statute says physicians must register by November of 2007 this program will not become operative until a rule package is passed, which would take up to two years to complete.

Approval of Minutes

MOTION: Dr. Pardo moved to approve the May 18, 2007 One Day Meeting Minutes, including Executive Session, the June 6-7, 2007 Regular Session Meeting Minutes, including Executive Session, the June 7, 2007 Regular Session Meeting Minutes, the July 10, 2007 Emergency Summary Action Meeting Minutes, and the July 13, 2007 Emergency Summary Action Meeting Minutes, including Executive Session.
SECONDED: Dr. Mackstaller
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

REVIEW OF EXECUTIVE DIRECTOR DISMISSALS

MOTION: Dr. Mackstaller moved to uphold the Executive Director's dismissals for cases 1-15 except for 3, 11, and 13, which will be discussed individually.
SECONDED: Dr. Lee
VOICE VOTE
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-07-0027A	M.W.	FARAN BASHIR, M.D.	32902	Uphold ED Dismissal
2.	MD-06-0907A	W.B.	DANIEL F. RYCHLIK, M.D.	31797	Uphold ED Dismissal

W.B. was present and spoke during the call to public. WB and his wife filed this complaint with concerns of Dr. Rychlik's infertility treatment. WB alleged Dr. Rychlik failed to provide copies of medical records and failed to address a report indicating the presence of scar tissue. WB stated that he and his wife consulted with another physician who immediately addressed their issues using the same medical file as Dr. Rychlik. WB also stated that once he and his wife became aware of Dr. Rychlik's misdiagnosis, they requested a refund, but have they have had no contact with Dr. Rychlik since their message requesting a refund. WB asked the Board to reconsider the matter and hold Dr. Rychlik accountable for his incompetence.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-06-0327A	P.H.	PATTI A. FLINT, M.D.	23855	Reject the ED dismissal and place case on a future agenda for an Advisory Letter.

Dr. Flint was present and spoke during the call to public. She agreed and supported the decision to dismiss the case. She stated that P.H. loved the outcome of her breast surgery, but noted that the left breast was larger than the right. Dr. Flint offered to help her; however, P.H. did not want revision surgery. William Wolf, M.D., Medical Consultant, summarized the case for the Board. This case was reviewed by two Outside Medical Consultant's (OMC's) during the course of investigation and neither found a clear deviation from the standard of care. Staff found Dr. Flint met the standard of care and recommended the Board dismiss the matter. Dr. Petelin stated that the left breast being larger than the right is clearly identified in the medical records. Dr. Petelin commented that P.H. was harmed by Dr. Flint removing a larger amount of tissue from the smaller breast. Dr. Petelin opined that an Advisory Letter would be more appropriate.

MOTION: Dr. Petelin moved to reject the ED dismissal and place the case on a future agenda for an Advisory Letter.
SECONDED: Ms. Proulx
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-06-1014A	J.M.	SEEMEEN SIDDIQI, M.D.	27889	Uphold ED Dismissal

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-06-0941A	S.J.	GORDON E. GENTA, M.D.	15529	Uphold ED Dismissal
6.	MD-07-0075A	D.F.	GARY S. MACKMAN, M.D.	12411	Uphold ED Dismissal
7.	MD-06-1023A	B.B.	MICHAEL R. JERMAN, M.D.	17678	Uphold ED Dismissal
8.	MD-07-0086A	D.K.	JAMES Y. CHOI, M.D.	32010	Uphold ED Dismissal
9.	MD-07-0086B	D.K.	FREDERICK R. AHMANN, M.D.	10449	Uphold ED Dismissal

D.K. was present and spoke during the call to public with regards to ED Dismissal #s 8 and 9 involving Drs. Choi and Ahmann. D.K. stated the physicians did not properly treat her husband. She stated the medication prescribed to her husband for constipation did not produce a bowel movement. Her husband was discharged and, several hours after discharge, she called one of the physicians back to evaluate him. Her husband had a swollen bowel with bowel obstruction. D.K. stated that while the standard of care does not require perfection, it should demonstrate a level of skill from the physician. She also stated there is a preponderance of evidence in her case and the physicians were negligent. She asked that the Board reconsider the matter and hold the physicians accountable for their negligence.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-06-0819A	P.O.	STEPHEN D. GLACY, M.D.	17082	Uphold ED Dismissal
11.	MD-06-1020A	S.K.	MOHAMED N. AKL, M.D.	35205	Uphold ED Dismissal

Dr. Akl was present with legal counsel, Mr. Barry Halpern. Both Dr. Akl and Mr. Halpern agreed with the decision to dismiss the matter.

Dr. M. Sami Kassem was present and spoke during the call to public on behalf of his daughter, M.K. Dr. Kassem alleged Dr. Akl forced himself on M.K. as her physician when there was no emergent or immediate threat to her health at the time. Dr. Kassem stated he understood Dr. Akl was exercising his legitimate right to divorce M.K. According to Dr. Kassem, Dr. Akl contacted him and revealed his daughter's confidential medical history. M.K. was present and spoke during the call to public. She stated that she was frustrated that her rights had been violated but the Board claimed to have found no violation of the Arizona Medical Practice Act. She stated she had telephone records to prove the phone calls on October 4, 2006 and October 14, 2006. Dr. Akl's response to the allegations to the Board indicated he did not relay to her father any of her medical information. S.K. was also present and spoke during the call to public. She complimented the Board and stated she was impressed with their thoroughness and professionalism. She also stated that she is aware of Dr. Akl's attorney doing what he can to cover up Dr. Akl's actions and stated she would contact the media to get answers and she would do her best to protect M.K.'s rights.

Dr. Mackstaller pulled this case for discussion. She stated she felt that it was not the Board's role to be involved in a physician's divorce. Dr. Petelin asked for clarification in how the legal relationship exists with the treatment of a spouse with regard to the Health Insurance Portability and Accountability Act (HIPAA). Christine Cassetta, Board Legal Counsel, stated she was not fully aware of the federal law, other than how it implicates the Board's ability to obtain records, but if a physician is treating his spouse, there is a doctor-patient relationship established. The Board noted that the issue surrounded Dr. Akl talking with M.K.'s father about her medical history. M.K. alleged that Dr. Akl informed her father as her treating physician and not as her husband. Ingrid Haas, Medical Consultant, stated that she felt the information was shared as a family issue and not in regards to M.K.'s medical care.

MOTION: Dr. Mackstaller moved to uphold the ED dismissal.
SECONDED: Dr. Lee

Dr. Petelin opined that if there are abnormal actions taken by the physician it is the Board's responsibility to investigate. Dr. Haas stated that the some of comments that were made during the call to public were not previously shared during the investigation. Staff did not receive documentation during the course of the investigation, except for the police report regarding a protection order filed by Dr. Akl against M.K. and her sister. Erica Bouton, Case Manager, informed the Board that she contacted the complainant when Staff received the request for review of the ED dismissal. The complainant was informed of her opportunity to submit additional material in support of her case, but Staff did not receive anything. Ms. Griffen stated she found issues of domestic violence in this case and requested this case be sent back to the Case Management Office for further investigation. Dr. Mackstaller withdrew her previous motion. Ms. Cassetta stated the Board may request Dr. Akl be evaluated to determine his mental and/or physical ability to safely practice medicine. Kelly Sems, M.D., Chief Medical Consultant, informed the Board that Dr. Akl could undergo a psychiatric evaluation for the behavior alleged by the complainant and her family. Dr. Martin stated he wanted to make certain that the Board only address the medical issues. Ms. Cassetta stated the Board may request the Executive Director to review the matter and refer it to the proper authority.

MOTION: Dr. Martin moved to uphold the ED Dismissal.
SECONDED: Ms. Proulx
VOICE VOTE
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

The Board requested Mr. Miller refer the matter to the appropriate jurisdiction for any further investigation.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-06-0609A	M.S.	DEVINDER SINGH, M.D.	20589	Uphold ED Dismissal
13.	MD-07-0131A	A.A.	SCOTT A. WASSERMAN, M.D.	23328	Reject the ED dismissal. Continue the investigation and invite the physician for a formal interview at the conclusion of the investigation.

A.A. was present and spoke during the call to public. She briefly reiterated the poor quality of care she received from Dr. Wasserman. In November of 2006, Dr. Wasserman presented himself to A.A. as being experienced in performing blepharoplasty. A.A. decided to have upper and lower blepharoplasty procedures. Dr. Wasserman performed the upper blepharoplasty and rescheduled the lower blepharoplasty procedure. A.A. stated she was later informed Dr. Wasserman was not experienced in performing the lower blepharoplasty procedure. After months of miscommunication between A.A. and Dr. Wasserman, A.A. consulted another physician who advised her that Dr. Wasserman performed the surgery incorrectly. A.A. requested her medical records from Dr. Wasserman in January of 2007 to continue care with another physician. She stated Dr. Wasserman requested she sign a release in exchange for her records that prohibited her from filing a lawsuit. A.A. stated Dr. Wasserman misrepresented himself to her for financial gain and attempted to charge a fee for providing her medical records.

Gerald Moczynski, M.D., Medical Consultant summarized the case. Staff found no deviations from the standard of care and recommended the Board dismiss this case. Staff discovered Dr. Wasserman refunded the money for the procedures he did not perform. Dr. Moczynski stated A.A. was upset that she did not receive the total refund, which is what she anticipated. Vicki Johansen, Case Manager, informed the Board that A.A. was provided a copy of her medical record as she submitted copies of the procedure performed by Dr. Wasserman to Staff upon request. Dr. Mackstaller was concerned with Dr. Wasserman performing procedures in which he was not trained. Dr. Petelin stated that an Internist should not be performing this type of procedure. Dr. Wasserman stated in his response to the Board that he would stop performing this procedure. Dr. Petelin stated that he visited Dr. Wasserman's web site and Dr. Wasserman still has this procedure listed. Dr. Petelin opined that an Advisory Letter would be more appropriate so the Board can track this physician. Dr. Lee agreed that an Advisory Letter would be appropriate in this case for the purpose of tracking Dr. Wasserman and noted that if this case were to be dismissed, the Board could not reconsider it in the future.

MOTION: Lee moved to reject the ED dismissal and invite for a formal interview to review his scope of practice.
This motion was not seconded and; therefore, failed.

Ms. Cassetta stated the Board may request the case be sent back to analyze whether or not Dr. Wasserman should have performed this type of procedure. Dr. Pardo noted that the medical consultant who reviewed this case was a plastic surgeon. Mr. Miller stated it is typical practice of the Agency to use a medical consultant who specializes in the procedure performed. The Board agreed to interview Dr. Wasserman to determine if he was acting outside the scope of his training. Dr. Petelin noted this is Dr. Wasserman's fourth case before the Board in the past four years.

MOTION: Dr. Mackstaller moved to reject the ED dismissal to continue the investigation and invite the physician for a formal interview at the conclusion of the investigation.
SECONDED: Dr. Petelin
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
14.	MD-07-0227A	M.L.	RAMA K. MAGANTI, M.D.	34195	Uphold ED Dismissal
15.	MD-06-0894A	J.B.	ANDREW J. ALDRIDGE, M.D.	30031	Uphold ED Dismissal

ADVISORY LETTERS

MOTION: Dr. Lee moved to accept Advisory Letters 2-20, except #s 1, 3, 4, 7, 9, 16, and 18, which will be discussed individually.
SECONDED: Dr. Petelin
Vote: 9-yay, 0-nay, 0-abstain, 0-absent, 3-recuse.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0957A	AMB	STANLEY C. PENSE, M.D.	23170	Issue an Advisory Letter for failure to recognize an intra-abdominal foreign body. While there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.

Dr. Pardo pulled this case for discussion and noted that this case involved an incorrect sponge count by the nursing staff. Dr. Pardo stated she felt the nurse involved should be referred to the Arizona Board of Nursing. Dr. Petelin noted the sponge was

retained in the patient for a significant period of time. Dr. Petelin also noted that there were a number of physicians and other staff treating the patient that should have discovered and removed the sponge in a timely manner which might have prevented the patient's demise.

MOTION: Dr. Pardo moved to issue an Advisory Letter for failure to recognize an intra-abdominal foreign body. While there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.
SECONDED: Dr. Lee
VOTE: 8-yay, 1-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

The Board requested the case be referred to the Arizona Board of Nursing for their review of the nurse involved.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-06-0123A	L.H.	NGA T. DO, M.D.	28382	Issue an Advisory Letter for failure to recognize a pituitary lesion. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
3.	MD-06-0998A	C.N.	SYED Z. TAHIR, M.D.	19801	Issue an Advisory Letter for failure to adequately follow up with a postoperative right inguinal hernia patient.

Dr. Tahir was present with legal counsel, Mr. Steve Yost, and spoke during the call to public. Mr. Yost stated that C.N. was followed appropriately and the case should be dismissed. Dr. Tahir briefly summarized the case for the Board. C.N. presented to Dr. Tahir with an incarcerated recurrent incision hernia. She had two previous failed repairs of the hernia. He stated C.N. had been hospitalized for 24 hours before he first saw her. He gave her preoperative antibiotics and the surgery went well. He discharged her on antibiotics with orders to return if she had any problems. C.N. was seen by Dr. Tahir ten days postoperatively when an aspirated ceroma was noted. Dr. Tahir also saw C.N. on postoperative day 14, on which the ceroma was not noted, and he stated she was doing well. C.N. presented to the Emergency Room on postoperative day 26 and she requested another physician treat and monitor her care. Dr. Tahir stated this was not a case of a wound infection, but rather case of a mesh infection. Dr. Tahir stated he felt he satisfied his obligation to the patient and requested this case to be dismissed.

MOTION: Dr. Mackstaller moved to issue an Advisory Letter for for failure to adequately follow up with a postoperative right inguinal hernia patient.
SECONDED: Ms. Proulx
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-06-0959A	AMB	SYED Z. TAHIR, M.D.	19801	Re-notice Dr. Tahir on A.R.S. §32-1401(27)(e, q, and ll) and offer a consent agreement for a Letter of Reprimand. If Dr. Tahir declines, invite him for a formal interview.

Dr. Petelin pulled this case for discussion and requested the physician be re-noticed on A.R.S. §32-1401(27)(e, q, and ll). This is a case of an open cholecystectomy in which the needle count from the nursing staff was incorrect. Dr. Tahir noted the needle count was correct in his dictation. An x-ray was performed on the patient, but Dr. Tahir did not review the x-ray. The x-ray indicated two retained radiopaque laboratory sponge markers inside the patient. Dr. Petelin opined that had the physician reviewed and appropriately read the x-ray, the sponges would not have been retained. The patient left the operating room and later returned to have the sponges removed. William Wolf, M.D., Medical Consultant, clarified that Dr. Tahir had another chance to see the sponges three days later when seeing the patient. Dr. Martin requested Staff to draft a consent agreement including the violations noted by Dr. Petelin. Ms. Cassetta noted Staff would first need to re-notice Dr. Tahir with the additional violations.

MOTION: Dr. Petelin moved to re-notice Dr. Tahir on A.R.S. §32-1401(27)(e), (q), and (ll) and offer him a consent agreement for a Letter of Reprimand. If Dr. Tahir declines to sign, invite him for a formal interview.
SECONDED: Dr. Lee
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-07-0097A	L.G.	ALLEN R. GARDNER, M.D.	31108	Issue an Advisory Letter for failure to discuss the final CT results and for inadequate medical records. This matter did not rise to the level of discipline.
6.	MD-06-0530A	AZ DEPT. OF INSURANCE	SCOTT C. FORRER, M.D.	19296	Issue an Advisory Letter for failure to properly maintain records. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

Dr. Goldfarb recused himself from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-06-0593A	M.C.	ARTHUR J. O'CONNOR III, M.D.	6361	Issue an Advisory Letter for failing to recognize the wire was severed, for failing to retrieve the wire, and for inadequate medical

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
					records. The violations are minor or technical violations that are not of sufficient merit to warrant disciplinary action.

M.C. was present and spoke during the call to public. He stated this was the only procedure he has undergone that required guide wire placement. Shortly after the procedure, he felt excruciating pain and did not realize the guide wire was not removed. M.C. went to emergency room where the wire was removed and his pain was immediately eliminated. Mr. Dan Jantsch was also present and spoke during the call to public on behalf of Dr. O'Connor. He stated the guide wire was removed in the emergency room by an interventional radiologist. Mr. Jantsch noted Dr. O'Connor inaccurately documented that he used a needle to place the guidewire, which Dr. O'Connor admitted. Mr. Jantsch stated that neither of the two wires used during M.C.'s procedure were close to the size of the guidewire that was removed by the radiologist. Mr. Jantsch requested the Board remove the findings that indicate Dr. O'Connor allowed the wire to be retained in M.C. He stated it was not possible for the wire to have gone unnoticed for as long as the records indicate and stated there was not evidence to support this finding.

Dr. Wolf explained to the Board that the wire could have been retained by the physician pulling back the wire and shearing a piece off with the needle used to place it. He stated the preponderance of evidence indicates Dr. O'Connor left the wire in M.C. Dr. O'Connor argued in his response to the complaint that it would have been impossible to continue the procedure if the wire was retained because it was done under ultrasound guidance. Dr. Wolf stated this statement was untrue as the wire would have been difficult to visualize during the procedure.

MOTION: Dr. Mackstaller moved to issue the Advisory Letter.
SECONDED: Dr. Lee
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-06-0750A	D.P.	CHUBA B. ONONYE, M.D.	23372	Issue an Advisory Letter for failure to document and for failure to follow up on abnormal lab values. While there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.
9.	MD-06-0761A	M.D.	PATTI A. FLINT, M.D.	23855	Issue an Advisory Letter for excessive fat removal in the thigh area during liposuction. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

Dr. Flint was present and spoke during the call to public. She stated she was not made aware of the Advisory Letter until her attorney contacted her to inform her that the Board would be considering her case at the August 2007 Board Meeting. She summarized the case for the Board stating that M.D. presented to her in April of 2005 for a facelift but decided to not have the procedure at that time. She again presented to Dr. Flint in January of 2006 when she decided to undergo a facelift and liposuction. Postoperatively, M.D. complained of contour deformities of her inner thighs. Dr. Flint referred the Board to a letter of support she submitted to the Board from her expert witness that she met the standard of care. Dr. Flint concluded by stating she believed she met the standard of care.

M.D. was also present and spoke during the call to public. She stated Dr. Flint removed too much fat during the liposuction procedure. Dr. Flint admitted to M.D. that she removed too much fat and agreed to pay another physician to revise M.D.'s thighs. M.D. informed the Board she underwent the revision surgery three weeks prior to the board meeting. M.D. stated Dr. Flint had her sign a release form that prohibited her from taking further action against Dr. Flint.

The Board pulled this case for discussion and to obtain clarification on whether or not Dr. Flint was properly notified of the board meeting. Staff confirmed that Dr. Flint was mailed the appropriate notice for this meeting.

MOTION: Dr. Lee moved to issue an Advisory Letter for excessive fat removal in the thigh area during liposuction. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Dr. Petelin
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-06-0827A	AMB	JAMES N. YARUSSO, M.D.	31732	Issue an Advisory Letter for inadequate medical records. While there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.
11.	MD-07-0047A	A.M.	JOAN L. WILBURG-BOURNE, M.D.	30183	Issue an Advisory Letter for prescribing Naproxen to a patient on Warfarin without discussing the risks. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-07-0060A	AMB	WILLIAM L. MILLER, M.D.	5838	Issue an Advisory Letter for practicing medicine in another state while on inactive status in Arizona. While there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.
13.	MD-06-0753A	T.Y.	CHARLES MATLIN, M.D.	13975	Issue an Advisory Letter for the delay in treatment of acutely worsening arterial disease. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
14.	MD-06-0400A	AMB	LAWRENCE M. EILENDER, M.D.	12602	Issue an Advisory Letter for failure to obtain emergent imaging in a patient with evidence of intracranial pressure. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
15.	MD-07-0392A	AMB	RICHARD DALE, M.D.	4482	Issue an Advisory Letter for inappropriately disposing of medical records and for not having a written plan for disposing of the records.

Drs. Goldarb and Mackstaller were recused from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
16.	MD-06-1016A	AMB	ARTHUR J. O'CONNOR, M.D.	6361	Issue an Advisory Letter for failure to remove surgical wound packing prior to secondary closure. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

Mr. Jantsch was present and spoke during the call to public on behalf of Dr. O'Connor. He stated that this matter involved patient R.B. who presented to the hospital with a ruptured appendix and the nursing staff failed to remove a roll of Kling packing that should have been removed postoperatively. Mr. Jantsch referred the Board to a letter submitted by Dr. O'Connor regarding his reason for not documenting the removal of the Kling packing. The Kling packing was removed on postoperative day five. Mr. Jantsch stated the packing was not visualized on postoperative day four when Dr. O'Connor closed the wound. Mr. Jantsch also referred the Board to a copy of the hospital procedures he submitted to the Board. He stated the procedures indicate that it was the nursing staff's duty to remove the Kling packing and requested the Board dismiss this case.

Dr. Pardo pulled this case for discussion and stated that she felt this case should be referred to the Arizona Board of Nursing. Dr. Wolf clarified to the Board that Dr. O'Connor relied on the nursing staff to change the wound dressings postoperatively. Dr. O'Connor claimed the wound healed over the Kling in the time it took for the removal of the Kling. Dr. Wolf stated he has never seen a wound heal so quickly to granulate over a wound packing. Dr. Pardo opined that if it was not a written order for the nurse to remove the packing, the nurse might not have known to look for it. Dr. Pardo also opined that the Advisory Letter was appropriate in this case.

MOTION: Dr. Pardo moved to issue an Advisory Letter for failure to remove surgical wound packing prior to secondary closure. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Dr. Petelin
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOITON PASSED.

The Board requested this case be referred to the Arizona Board of Nursing if the order was documented for the nurse to remove the packing. If this was not a written order, the responsibility lies on the physician and the case will not be referred.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
17.	MD-06-1025A	AMB	GRACE A. HAYNES, M.D.	22571	Issue an Advisory Letter for failure to monitor for diabetes in a patient on Zyprexa. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
18.	MD-05-1071A	AMB	DANIEL M. LIEBERMAN, M.D.	28519	Issue an Advisory Letter for failure to adequately review the treatment plan. There is insufficient evidence to support disciplinary action.

Dr. Lefkowitz recused himself from this case. Dr. Lieberman was present and spoke during the call to public. He stated he felt he did not do anything wrong and the case should be dismissed. He explained his part of the procedure to the Board and noted he was advised by his attorney to settle the malpractice claim. Dr. Lieberman noted that the three physicians reviewed this case and all were in agreement that he met the standard of care. He concluded by stating the definition of an Advisory Letter is to indicate potential harm to the public, but does not believe he was responsible for any harm to the patient. Dr. Goldfarb noted that Dr. Lieberman stated to the Board that he only placed the frame on the patient's head and targeted the area on the computer, but he billed with a Current Procedural Terminology (CPT) code of 61793. Dr. Goldfarb also noted that this code is for more than what Dr. Lieberman claims to have performed. Dr. Goldfarb stated there were also other ways to have treated the patient besides radiation.

MOTION: Dr. Mackstaller moved to issue an Advisory Letter for failure to adequately review the treatment plan. There is insufficient evidence to support disciplinary action.
SECONDED: Dr. Lee
VOTE: 8-yay, 0-nay, 0-abstain, 1-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
19.	MD-07-0015A	K.B.	JOSEPH A. LONGO, M.D.	18636	Issue an Advisory Letter for failing to properly place the acetabulum prosthesis during total hip arthroplasty and for failing to recognize the possibility of impingement as a cause for the patient's continued pain. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

K.B. was present and spoke during the call to public. She stated that before her surgery, Dr. Longo discussed with her in great detail how the quality of her life would improve. She stated that her quality of life diminished after her surgery. K.B. underwent revision surgery fifteen months after her surgery at the Mayo Clinic where it was determined she had one leg shorter than the other by four centimeters. K.B. informed the Board that the Mayo Clinic also informed her that the implant Dr. Longo placed was placed incorrectly. She stated she felt neglected by Dr. Longo postoperatively.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-06-0507A	AMB	MERL J. PEACHEY, M.D.	5375	Issue an Advisory Letter for failure to report a misdemeanor arrest.

Dr. Petelin recused himself from this case.

OTHER BUSINESS

MOTION: Dr. Goldfarb moved to accept the proposed Consent Agreements in items 1-6, 20-21, and 23-25.
SECONDED: Ms. Proulx
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, Dr. Lee, and Dr. Schneider.
Vote: 8-yay, 0-nay, 0-abstain, 0-recuse, 4-absent.
MOTION PASSED.

MOTION: Dr. Petelin moved to accept the draft Findings of Fact, Conclusions of Law and Order in items 10-19 with the exception of number 12, which will be discussed individually.
SECONDED: Dr. Goldfarb
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-1022A	AMB	JOHN V. DOMMISSE, M.D.	22164	Accept proposed consent agreement for a Decree of Censure for releasing confidential Board information.
2.	MD-06-0757A	AMB	HARRY D. GOLDWASSER, M.D.	20842	Accept proposed consent agreement for a Letter of Reprimand for habitual intemperance and diversion of narcotics. Five year Probation with MAP terms.
3.	MD-07-0144A	A.M.	MARK R. LONQUIST, M.D.	22778	Accept proposed consent agreement for a Letter for Reprimand for engaging in a sexual relationship with a patient and for making a false statement to the Board. One Year Probation and 20 hours CME in boundary issues.
4.	MD-06-0442A	AMB	ROBERT S. KINKADE, M.D.	26410	Accept proposed consent agreement for a Letter of Reprimand for failing to obtain appropriate indications prior to performing bilateral mastectomies and for failure to maintain adequate medical records.
5.	MD-06-0840A	AMB	SMITA C. PATEL, M.D.	35013	Accept proposed consent agreement for failure to adequately supervise physician assistants.
6.	MD-07-0052A	AMB	MARK K. PATTON, M.D.	23562	Accept proposed consent agreement for violating a Board Order.
7.	MD-07-L020A	AMB	MEHDY ZARANDY, M.D.	N/A	Uphold ED decision to deny licensure.

Dr. Zarandy was present and spoke during the call to public. He stated his license was denied due to a question on the application regarding probation of a medical license to which he answered no. During Dr. Zarandy's residency at the Eastern Virginia Medical School from 2001-2002, he stated the program was placed on probation for the year. Dr. Zarandy contended that he was never on probation. Anita Shepherd, Case Manager, gave the Board a brief summary of the case. Dr. Zarandy was placed on academic probation during his residency due to poor fund of knowledge and lack of basic skills. The Board confirmed the documentation in this case supports the fact that Dr. Zarandy, and not the program, was placed on probation.

MOTION: Dr. Lee moved to uphold the Executive Director's decision to deny the license.

SECONDED: Dr. Petelin
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members were absent: Dan Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-06-0047A	J.P.	DARRELL J. JESSOP, M.D.	23441	Deny the Motion for Rehearing or Review.

Dean Brekke, Assistant Attorney General, stated there is substantial evidence to support disciplinary action and the record does set the standard of care. Staff recommended the Board deny Dr. Jessop's request for rehearing or review.

MOTION: Dr. Petelin moved to deny the motion for rehearing or review.
SECONDED: Dr. Lee
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-05-0263A	J.K.	SCOTT C. FORRER, M.D.	19296	Grant the Motion for Rehearing or Review and continue the formal interview to obtain more information from the physician or to further discuss the case.

Dr. Goldfarb recused himself from this case. Dr. Forrer was present and spoke during the call to public. He briefly summarized the case for the Board and his reason for filing his motion. Dr. Forrer claims he did not hear from the Board for a year after his initial notice letter of the investigation in May 2005. He stated he provided all medical records requested by Staff and assumed all records were submitted to the Board. Dr. Forrer received a CD containing the investigative file, but stated that the facts were inaccurate and stated all of the patient medical records were not provided to the medical consultant who reviewed this case. He stated he then received a letter inviting him to a formal interview in January 2007. Dr. Forrer had submitted a lengthy response to the Board in September 2006 addressing the medical records issue, but stated there was no documentation on the CD from Staff requesting the medical consultant to review and respond to his letter. Dr. Forrer stated he felt the Board should reconsider his case, review all materials and dismiss the matter. Anne Froedge, Assistant Attorney General, referred the Board to a memorandum she had provided to the Board and stated that the Board's options were outlined for their consideration.

MOTION: Dr. Lee moved to deny the motion for rehearing or review.
This motion was not seconded and therefore failed.

MOTION: Dr. Martin moved to grant the motion for rehearing or review and continue the formal interview to obtain more information from the physician or to further discuss the case.
SECONDED: Dr. Mackstaller

Dr. Mackstaller asked Staff what the next step would be. Ms. Cassetta explained that Dr. Forrer would be invited back for a formal interview to discuss the issues he raised in his motion for rehearing.
VOTE: 8-yay, 0-nay, 0-abstain, 1-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-05-0340A	C.T.	RENE A. LUCAS, M.D.	19775	Accept draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to recognize addictive behavior, for failing to obtain medical records of prior treating physicians, for prescribing Duragesic patches in a manner that circumvented the rules for prescribing and that was equivalent to pre-dating, and for signing an undated prescription.
11.	MD-06-0208A	AMB	FRANCIS M. PRICE, M.D.	17392	Accept draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for making a false statement to the Board, specifically for failing to state he was arrested for DUI in 1993 and for failure to report, as required, his DUI arrest of August 14, 2005 and subsequent conviction.
12.	MD-06-0062A	AMB	STEPHEN P. SUTTON, M.D.	28812	Accept draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to appropriately treat a Pseudomonas infection of the urinary tract, for failing to perform a nephrectomy and failing to discuss all the alternatives with a patient.

Ms. Cassetta explained that Dr. Sutton submitted a request for word changes to the draft, which she had made. She stated Dr. Sutton requested the Board remove the statement "H.S. developed", however, she stated that, upon her review of the transcript, the Order reflects Dr. Sutton's own statement.. Based upon Ms. Cassetta's recommendations, Dr. Martin entertained a motion to accept the draft as amended.

MOTION: Dr. Lee moved to accept the draft Findings of Fact, Conclusions of Law and Order with the modifications as recommended by counsel.
SECONDED: Ms. Griffen
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
13.	MD-06-0513B	I.R.	JOHN P. WOHLER, M.D.	25661	Accept draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to perform an adequate neurological examination, failure to properly address neurologic complaints and symptoms in a patient with gliomatosis cerebri, and failure to arrange for appropriate emergency intervention. One Year Probation with 20 hours CME in the diagnosis of intracranial lesions such as brain tumors and hemorrhages.

I.R. was present and spoke during the call to public on behalf of her husband, the patient. She stated Dr. Wohler used excuses by pointing the blame on what others failed to do during his formal interview before the Board. She claimed Dr. Wohler ignored all of her husband's signs of physical distress and by his own admission, Dr. Wohler stated that if he were in his own practice he would have listened more to the patient's complaints. I.R. stated Dr. Wohler took a hippocratic oath to be a healer; instead he withheld medical care for her husband.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
14.	MD-05-1068A	AMB	CHARLES A. BOLLMANN, M.D.	6020	Accept draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for inappropriate care, inadequate records, inadequate supervision, inappropriate billing and making false statements. Two Year Probation with random chart reviews.
15.	MD-06-0470A	N.J.	SCOTT A. WASSERMAN, M.D.	23328	Accept draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to provide adequate anesthesia during a liposuction procedure and failure to maintain adequate medical records. One Year Probation with 20 hours CME in sedation and perioperative documentation.

Dr. Petelin noted similarities in cases brought before the Board regarding Dr. Wasserman. Dr. Petelin stated that each time Dr. Wasserman is brought before the Board he states he knew he was not qualified for the procedure performed and he will not do it again. Dr. Petelin stated there is a trend with this physician and wondered how the Board could use this case to track him. Ms. Cassetta informed the Board that once the Board approves the Order, it becomes effective if Dr. Wasserman does not file an appeal, and once effective, it becomes part of his Board history that can be used by the Board in considering future cases.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
16.	MD-06-0187A	C.S	ELA M. TIMBADIA, M.D.	16679	Accept draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to abandon the procedure to place a central catheter after multiple attempts in the face of anatomical abnormalities and for failure to recognize the central catheter was inappropriately placed.
17.	MD-06-0173A	M.S.	WILLIAM E. MORA, M.D.	13088	Accept draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inappropriate prescribing and inadequate medical records and for prescribing for non-therapeutic purposes.
18.	MD-05-0761A	M.T.	PAUL R. MAZZARELLA, M.D.	18157	Accept draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing or refusing to maintain adequate medical records and prescribing medications without appropriate physical examination, laboratory studies and documented follow-up.
19.	MD-06-0950A	AMB	MOHAMMAD Z. QURESHI, M.D.	8269	Accept draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for improper diagnosis and treatment of patients with chronic pain, specifically the improper use medications, improper procedural pre-medication, inadequate understanding of anatomy and for improper billing. Ten year Probation restricting Dr. Qureshi from performing any pain management-related injection therapies. The physician may petition the Board for termination of Probation upon completion of a PACE evaluation for his global fund of knowledge in anesthesia and with specific emphasis in peripheral nerve blocks, and demonstrating that he has complied with the terms of that evaluation, and further demonstrating to the Board that he is competent to resume pain management related therapies.

M.K. was present and spoke during the call to public on behalf of Dr. Qureshi. She stated she was forced to medically retire this year and her quality of life had slowly declined as she became homebound. She only left her home for medical appointments as she felt helpless and reached a point where walking became overwhelming for her. M.K. was referred to Dr. Qureshi by two physicians and found the injections to be quite painful but continued to see him for treatment. She informed the Board she is

unable to continue her treatments due to the AMB forcing Dr. Qureshi to close his practice and stated she found the AMB's disregard for her treatment unacceptable. M.K. urged the Board to dismiss the charges against Dr. Qureshi. She stated her life has improved because of Dr. Qureshi and asked the Board to reconsider their decision.

R.K.D. was also present and spoke during the call to public. R.K.D. was a patient of Dr. Qureshi's for the past four months. He stated he had been to several different physicians and tried several different ways to heal his pain. He stated he is no longer taking pain medications at all when four months ago he was taking Codeine like candy. He stated he has a lot of physical limitations from problems related to his military service. Thanks to Dr. Qureshi, R.K.D. stated he can now perform activities that he could not do before. R.K.D. stated he would love to see Dr. Qureshi continue his practice for his sake and for the sake of others as Dr. Qureshi has found a way to help individuals once chemically dependent,

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-07-0036A	J.T.	SAMPURNARAO KOPPULA, M.D.	13707	Accept proposed consent agreement for Surrender of an active license.
21.	MD-07-0085A	M.G.	BRIAN DIEP, M.D.	34428	Accept proposed consent agreement for a Letter of Reprimand for failing to appropriately evaluate and treat a patient with a horse bite injury to her hand and for failing to maintain adequate medical records.
22.	MD-07-L015A	AMB	PATRICK J. DEAN, M.D.	N/A	Uphold ED decision to deny licensure.

Dr. Dean was present and spoke during the call to public with his legal counsel, Mr. Paul Giancola. Dr. Dean has been board certified in pathology for 25 years, his practice is based in Memphis, Tennessee and he works with gastroenterologists worldwide. Dr. Dean stated that when his practice expanded geographically, he mistakenly assumed he could look at laboratory reports in other states as a typical consultation. He informed the Board that North Carolina granted him a license with a Letter of Reprimand due to this assumption. Dr. Dean also stated that he mistakenly read laboratory reports for Arizona patients, but they were later forwarded to an Arizona licensed pathologist to re-review once he became aware of his mistake. Dr. Dean assured the Board that his practice recently implemented a new computer program that prevents the pathologist from signing off on a chart for a patient in a state in which that physician is not licensed. He apologized to the Board for his mistake and stated he loves caring for patients as it is his joy in life. Mr. Giancola reiterated that the North Carolina Board issued Dr. Dean a license with a Letter of Reprimand. He stated there was no patient harm involved and that it was an innocent mistake. He requested the Board reconsider the denial and grant Dr. Dean a license to practice in Arizona so that he has the opportunity to continue to provide the valuable service he provides in other states.

Dr. Martin pulled this case for discussion and noted Dr. Dean spoke during the call to public with his attorney. Anita Shepherd, Case Manager, summarized the case for the Board. Dr. Dean did not hold a license in North Carolina when he practiced in that state after being notified of the risk of being reprimanded by their Board. Dr. Dean reviewed five specimens in Arizona without holding a license in Arizona. He had another physician who is licensed in Arizona re-review the specimens, but only Dr. Dean's reports are found in the patient files. Dr. Petelin noted Dr. Dean holds 23 state licenses to practice medicine. Dr. Lee stated that is not unusual for telemedicine physicians. The Board noted that Dr. Dean stated in letters that he would take the risk of reading the reports without being licensed and also noted a letter in his attorney's file advising him of the potential risks.

MOTION: Dr. Lee moved to uphold the Executive Director's decision to deny the license.
SECONDED: Dr. Petelin
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members were absent: Dan Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
23.	MD-07-0524A	AMB	RODERIC S. HUBER, M.D.	4488	Accept proposed consent agreement for Surrender of an active license.
24.	MD-07-0035A	M.C.	THOMAS J. GROVES, M.D.	5104	Accept proposed consent agreement for a Letter of Reprimand for mismanagement of a chronic pain patient, predating prescriptions for narcotics, for prescribing narcotics without first conducting an evaluation and for failure to maintain adequate records.
25.	MD-07-0567A	AMB	THOMAS J. GROVES, M.D.	5104	Accept proposed consent agreement for Surrender of an active license.

Wednesday, August 8, 2007

Call to Order
The meeting was called to order at 9:30 a.m.

Roll Call
The following Board Members were present: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members were not present: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.

Call to Public
Statements issued during the call to public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0693A	S.S.	ROBERT L. MAHANTI, M.D.	20847	Issue an Advisory Letter for failure to maintain adequate medical records including failure to document that he informed the patient of long term consequences of topical ocular steroids and failure to recognize the side effects of the medication. Obtain 20 hours CME for drug therapy, specifically in ophthalmologic steroids, and medical records.

Dr. Mahanti was present with legal counsel, Mr. Paul Giancola. Drs. Lee and Lefkowitz were recused from this case. Dr. Moczynski summarized the case for the Board. Staff found Dr. Mahanti deviated from the standard of care by failing to advise S.S. of long term side effects of topical steroids and failing to document this in the patient's file. Dr. Mahanti stated he prescribed topical steroids for S.S. to alleviate inflammation to dry eyes from contact lens wear. He stated that unfortunately her cataracts worsened and she required surgery. He also stated that there is good evidence with follow up visits and phone records that document the information was communicated with S.S. Dr. Mackstaller led the questioning. S.S. presented to the emergency room in 1995 and saw Dr. Mahanti for follow up care. S.S. had a chemical burn to her eye and was prescribed TobraDex by another physician before she presented to Dr. Mahanti. Dr. Mahanti did not see her again until 2000. S.S.s complaint at that time was dry eyes and Dr. Mahanti diagnosed her with dry eye symptoms. Dr. Mackstaller questioned why Dr. Mahanti did not document cataracts in S.S.'s chart each time she presented to his office for follow up as she had a history of cataracts upon presentation. Dr. Mahanti stated he did not dilate S.S.'s eyes each time he saw her and he can only visualize the cataracts when her eyes were dilated.

Dr. Mahanti continued S.S.'s prescription for TobraDex in April of 2002 and stated he informed her that with her history of cataracts, the TobraDex may aggravate them. Dr. Mahanti also advised her to limit her contact lens wear; however, this discussion was not documented. He stated that in March of 2002, his plan was to stop the TobraDex drops for lubrication, prescribed Patanol and instructed her to come back if her eyes worsened. S.S. was seen in April 2002 and Dr. Mahanti noted the Patanol did not work. S.S. stopped taking the TobraDex in December 2003 and started taking it again in March 2004. Dr. Mahanti informed the Board that there is no ophthalmological literature that indicates dosage or duration of therapy of topical steroids. He stated some people do not know what the lens susceptibility is to topical steroids. Dr. Mahanti stated the standard of care in the community is to dilate a patient's eyes when symptoms are present. He stated a patient could go a number of years without dilation and this would still be considered the standard of care.

In closing, Mr. Giancola referred to four ophthalmologists in the state who reviewed this patient's care and submitted letters in support. He stated that each physician said the standard of care is exactly as Dr. Mahanti described it to be. Mr. Giancola stated S.S. was closely followed during her treatment by Dr. Mahanti and strongly believes that Dr. Mahanti acted reasonably in this case. He requested the Board dismiss this case as the standard of care was met. Dr. Mackstaller stated that this case involved a patient who wanted to wear contacts, despite burning eyes and multiple side effects, but found Dr. Mahanti's documentation to be very poor. Dr. Mackstaller stated she is aware that ophthalmologists prescribe steroids, but that they are generally prescribed for a shorter period of time. Dr. Mackstaller did not believe this case rises to the level of discipline.

MOTION: Dr. Mackstaller moved to issue the physician an Advisory Letter for failure to document that he informed the patient of long term consequences of topical ocular steroids and for failure to maintain adequate patient records. Obtain 40 hours CME in drug therapy and medical records.
SECONDED: Ms. Griffen

Dr. Petelin asked if the hours could be decreased from forty to twenty. He stated he would be more comfortable with requiring twenty hours CME. Dr. Petelin found Dr. Mahanti to be very knowledgeable with regard to medications, but still felt he could use an upgrade with his record keeping and stated he would be in favor of the motion if the CME hours were decreased. Both Drs. Mackstaller and Griffen agreed to amend the motion. Dr. Pardo wondered if it would be redundant to include in the motion "failure to maintain adequate medical records" and "failure to document." Dr. Mackstaller stated Dr. Mahanti did fail to inform the patient, but also felt there were overall recordkeeping issues. She stated his records were not as complete as they should have been, but noted Dr. Mahanti remedied his recordkeeping by switching to an electronic record program.

AMENDED MOTION: Dr. Mackstaller moved to issue the physician an Advisory Letter for failure to maintain adequate medical records including failure to document that he informed the patient of long term consequences of topical ocular steroids and failure to recognize the side effects of the medication. Obtain 20 hours CME for drug therapy, specifically in ophthalmologic steroids, and medical records.
SECONDED: Ms. Griffen
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members were absent: Dan Eckstrom, Dr. Krishna, and Dr. Schneider. The following Board Members were recused from this case: Drs. Lee and Lefkowitz.
VOTE: 7-yay, 0-nay, 0-abstain, 2-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-06-0777A	AMB	ANDREW P. SMITH, M.D.	28031	Issue an Advisory Letter for failure to timely act upon a surgical complication. This was a minor or technical error. Obtain 20 hours CME in recordkeeping.

Dr. Smith was present with counsel, Mr. Rick Delo. Dr. Petelin stated he knew Dr. Smith, but it would not affect his ability to adjudicate the case. Dr. Wolf summarized the case for the Board. Staff found Dr. Smith deviated from the standard of care by failing to work up the damaged ureter when the presence of ureter tissue was confirmed in the pathology report. It was found to be a mitigating factor that the patient had multiple previous pelvic operations that increased the risk of a ureteral injury. Staff recommended the Board issue Dr. Smith an Advisory Letter at their June 2007 Board Meeting; however, the Board rejected the Advisory Letter and requested Staff invite Dr. Smith for a formal interview. Dr. Smith stated he did not dispute the Board's findings. Dr. Petelin led the questioning and stated he reviewed the medical records and failed to see any documentation that Dr. Smith examined the patient or discussed the pending surgery with the patient. Dr. Smith first saw the patient in the emergency room where he conducted a physical examination and discussed with her the computed tomography (CT) scan findings; however, there was no note or written documentation by Dr. Smith that he saw the patient. Dr. Smith stated the patient had specifically requested a general surgeon perform her surgery rather than a gynecological surgeon; therefore, Dr. Smith did not consider contacting a gynecological surgeon for this surgery.

Dr. Smith's operative report was dictated twenty minutes prior to the end of the surgery as his resident finished the surgery. Dr. Smith stated he was stunned to learn there was ureter tissue present in the patient's pathology report. Dr. Petelin noted that in Dr. Smith's response, he stated he discussed this with the patient; however, there was no documentation in the record of this discussion. Dr. Smith stated he saw a patient who was rapidly improving postoperatively with no signs of a ureteral injury, which is why he did not move forward with the tissue present in the pathology specimen. The patient began to experience problems with abdominal distension and overall weakness; however, she had no wound drainage or back pain. Dr. Petelin was concerned with the postoperative records that indicated the possibility of intermittent or incomplete intestinal obstruction. Dr. Petelin stated he was disturbed that Dr. Smith did not consider that her symptoms may have been related to the piece of ureter tissue found in pathology. Dr. Smith stated he was stunned to find that the patient had an obstructed right ureter despite the clinical picture and stated if he was faced with the same situation now, he would respond differently.

In closing, Mr. Delo stated there was no issue of whether or not Dr. Smith should have preformed the surgery, or whether or not he performed it appropriately. Dr. Smith did not try to hide the ureter tissue in the pathology report from the patient as there are records from Scottsdale Hospital indicating that she knew about it. He stated Dr. Smith properly treated her based on her clinical signs and symptoms. There were no aggravating factors found in this case and Dr. Smith has no prior Board history. Dr. Petelin was concerned that Dr. Smith failed to make an attempt to identify the ureter during the surgery. He was concerned with the pathology report and lack of documentation. Dr. Petelin found it mitigating that Dr. Smith has no prior Board history. He stated this was a technical mistake in failure to respond adequately to the presence of ureter tissue in the pathology report and the failure to make an attempt to identify the ureter tissue at the initial surgery. This matter does not rise to the level of discipline. Dr. Petelin stated Dr. Smith could benefit from better documentation.

MOTION: Dr. Petelin moved to issue the physician an Advisory Letter for failure to timely act upon a surgical complication. This was a minor or technical error. Obtain 20 hours CME in recordkeeping.
SECONDED: Ms. Proulx

Dr. Goldfarb was concerned with the amount of time between discovery of the ureter tissue the in the pathology specimen and the time that it was identified as a problem. Dr. Martin noted in Dr. Smith's testimony that not only was it not done, but it was not even considered. Dr. Martin stated he was concerned with this patient's follow up care. Dr. Martin spoke against the Advisory Letter and was more in favor of a Letter of Reprimand.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ms. Griffen, Dr. Lee, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members voted against the motion: Dr. Goldfarb, Dr.

Lefkowitz, Dr. Mackstaller, and Dr. Martin. The following Board Members were absent: Dan Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 5-yay, 4-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-06-0968A	AMB	SYED Z. TAHIR, M.D.	19801	Issue an Advisory Letter for performing unnecessary surgery. There is insufficient evidence to support disciplinary action.

Dr. Tahir was present with counsel, Mr. Steve Yost. Dr. Petelin stated he knew both Dr. Tahir and Mr. Yost, but it would not affect his ability to adjudicate the case. Dr. Wolf summarized the case for the Board. This case came to the attention of the Board as a result of a medical malpractice settlement. Staff found Dr. Tahir deviated from the standard of care by failing to obtain additional clinical images on a patient whose clinical presentation did not seem to be consistent with what appeared to be free air on the upright chest x-ray. Dr. Tahir stated the only diagnosis in his mind when he saw this patient was that she had free air under her diaphragm and she had a perforated viscous. His diagnosis, at that time, was a small perforation that sealed off and abdominal aspiration. He stated it was his obligation to discuss the risks and benefits, which he did. He recommended a CT scan; however, from 2003-2004, the backlog for a CT scan in the Emergency Room at the hospital was approximately 10-12 hours. He stated that a simple CT scan could not be obtained sooner than five to six hours. Dr. Petelin led the questioning. Dr. Tahir did not consider doing any other studies on this patient as he could not perceive that it would be anything else but a perforated viscous. Dr. Tahir had not heard of Chilaiditi Syndrome until the patient had informed him of it.

Postoperatively, Dr. Tahir consulted with an internist who indicated that he did not find any reason for the CT scan. The patient was readmitted shortly after her discharge with dehydration. Dr. Tahir informed the patient she may have a perforation and should obtain a CT scan to see where it was coming from and asked her what she would like for him to do. Dr. Tahir also informed her of other options as he wanted her consent before proceeding. She wanted surgery without obtaining a CT scan first. Dr. Goldfarb stated the value of a CT scan would be more known to the physician rather than the patient and opined Dr. Tahir would have been the best judge in regard to having the CT scan or not. Dr. Martin stated he failed to see the why there was a rush to surgery and commented that there would have been no harm in waiting. In closing, Mr. Yost emphasized that the expert in litigation concluded that the standard of care was satisfied in this case. Mr. Yost reminded the Board that the patient did consent to the surgery and the consent reflects that she was explained alternatives and elected to proceed. Mr. Yost believed the standard of care was met and disciplinary action was not appropriate in this case. Dr. Petelin stated the patient did sustain harm and underwent a surgery that proved to be unnecessary. He opined that the burden of proof is on the surgeon to operate and take care of a complication. Dr. Petelin did not believe this case rises to the level of discipline as there is insufficient evidence to support disciplinary action.

MOTION: Dr. Petelin moved to issue the physician an Advisory Letter for performing unnecessary surgery. There is insufficient evidence to support disciplinary action.
SECONDED: Dr. Goldfarb

The Board reviewed the patient's films and Dr. Wolf confirmed that the appearance on the x-ray was consistent with free air. He stated there were radiologists who reviewed the same films and agreed.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

Call to Public
Statements issued during the call to public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-06-0664A	AMB	ANTHONY T. YEUNG, M.D.	6424	Issue an Advisory Letter for failure to adequately monitor the patient for vascular and/or bowel injuries following a perforation of the anterior ligament during spine surgery. This is a technical violation that does not rise to the level of discipline. There is insufficient evidence to support discipline.

Dr. Yeung was present with counsel, Mr. Winn Sammons. Both Dr. Martin and Dr. Petelin stated they knew Dr. Yeung, but it would not affect their ability to adjudicate the case. Gerald Moczynski, M.D., Medical Consultant, stated he was not the reviewer on this case and recused himself from any recommendations in this case as he knew Dr. Yeung. Dr. Moczynski summarized the case for the Board. This matter was brought to the attention of the Board as the result of a medical malpractice settlement. Staff found Dr. Yeung deviated from the standard of care by failing to constantly visualize the shaver under C-Arm Fluoroscopy as it was used and for failing to look for free air on an x-ray prior to discharge from the recovery room. Dr. Yeung admitted and took full responsibility for the injury sustained. He stated this was the first and only bowel injury in over 8,000 endoscopic discectomies and

3,000 patients. Dr. Goldfarb led the questioning. Dr. Yeung stated he knew he had violated the annulus with the shaver used during the spine surgery. Dr. Yeung's plan was to postoperatively observe the patient for abdominal pain, nausea and vomiting. Dr. Goldfarb noted that the medical records did not indicate the anesthesiologist or nursing staff was made aware of the complication. Dr. Goldfarb commented the nursing staff should have been made aware, so they would have specifically looked for any bleeding or abdominal symptoms during their observation of the patient.

The patient was observed for an hour and a half when the last vital signs were taken and then released a half hour later. Dr. Goldfarb wondered if Dr. Yeung thought it was reasonable for him to send the patient home after two hours and not admit him for further observation. Dr. Yeung made the decision using his best clinical judgment to have the patient be monitored at home. Dr. Goldfarb opined the hospital setting would have been better due for the appropriate personnel to provide patient care. Dr. Yeung stated he felt that if the patient were to have symptoms, the two hours would have been plenty of time to resolve the problem and have a surgeon correct it. Dr. Petelin wondered if the patient was examined just prior to discharge, and if so, the examination would have been somewhat modified and ameliorated by medication and a residual from the anesthetic. Dr. Yeung stated each complication he encounters in his practice is added to his list of risks on his consent form. In closing, Mr. Sammon stated there was no attempt on Dr. Yeung's part to conceal that this complication occurred. He reminded the Board that the discharge instructions specifically told the patient to call if there is any persistent vomiting or nausea. Mr. Sammon believed this matter was quickly addressed and requested the Board dismiss this case.

MOTION: Dr. Pardo moved to go into executive session.
SECONDED: Dr. Martin
Vote: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

The Board went into Executive Session for legal advice at 3:23 p.m.
The Board returned to Open Session at 3:25 p.m.
No deliberations or discussions occurred during Executive Session.

Dr. Yeung stated that if he had acted differently at the time, the outcome would have remained the same. Dr. Goldfarb stated the issue is not the procedure performed or the tool that Dr. Yeung used during the procedure. He stated that the issue is the failure to monitor the patient after a very serious major complication of spine surgery. Dr. Goldfarb stated Dr. Yeung deviated from the standard of care by allowing the patient with this particular injury, to be discharged from the hospital in less than two hours. The standard of care would have required the physician to have observed the patient in the hospital. Dr. Goldfarb noted actual harm as the injury to the bowel with perforation to the bowel. Dr. Goldfarb identified potential harm as the failure to recognize a complication between the time when the injury occurred and the time that the patient received care.

MOTION: Dr. Goldfarb moved for a finding of unprofessional conduct in violation of A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Ms. Griffen

Dr. Lee clarified that the concern is not that the bowel injury occurred, the issue was recognizing that it occurred.

VOTE: 8-yay, 1-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

Dr. Goldfarb believed the seriousness of the potential for injury mandated a motion for a Letter of Reprimand.

MOTION: Dr. Goldfarb moved for a Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to adequately monitor the patient for vascular and/or bowel injuries following a perforation of the anterior ligament during spine surgery.
SECONDED: Dr. Lee

Dr. Pardo noted that Dr. Yeung did recognize the anterior perforation. Dr. Petelin spoke against the motion and stated that if there was an injury, it would have been obvious within the two hours that the patient was monitored postoperatively. Dr. Petelin was in favor of an Advisory Letter.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, and Dr. Lee. The following Board Members voted against the motion: Dr. Lefkowitz, Dr. Mackstaller, and Dr. Petelin. The following Board Members were abstained: Dr. Martin, Dr. Pardo, and Ms. Proulx. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 3-yay, 3-nay, 3-abstain, 0-recuse, 3-absent.
MOTION FAILED.

Dr. Petelin stated the complication was adequately handled and this case does not rise to the level of discipline.

MOTION: Dr. Petelin moved to issue the physician an Advisory Letter for failure to adequately monitor the patient for vascular and/or bowel injuries following a perforation of the anterior ligament during spine surgery. This is a technical violation that does not rise to the level of discipline. There is insufficient evidence to support discipline.
SECONDED: Dr. Lefkowitz

Dr. Petelin stated that in recommending the Advisory Letter he is not in disagreement to letting the patient go home after the two hour observation. He stated there is insufficient evidence to support discipline. Dr. Martin spoke in favor of the motion and stated that an Advisory Letter was appropriate so that the Board may track it.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ms. Griffen, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, and Ms. Proulx. The following Board Members voted against the motion: Dr. Goldfarb and Dr. Lee. The following Board Member abstained: Dr. Pardo. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 6-yay, 2-nay, 1-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-06-0927A	P.C.	NEIL TRACHTENBERG, M.D.	10078	Draft Findings of Fact, Conclusions of Law and Order for performing a procedure to which the patient did not consent.

P.C. was present and spoke just before the interview. She stated that a patient consent form is a legal document and a contract between the patient and her physician and this form should be reviewed prior to any procedure. As a result of undergoing an endometrial ablation without her consent, P.C. stated she is faced with a cascade of issues. She stated that because Dr. Trachtenberg broke his trust with her, she did not agree to follow up treatment. She stated that when she asked postoperatively how this happened, he told her he decided to do it. Dr. Trachtenberg was present with legal counsel, Mr. Gordon Lewis. Dr. Petelin stated he knew Dr. Trachtenberg, but it would not affect his ability to adjudicate the case. Ingrid Haas, M.D., Medical Consultant, summarized the case for the Board. Staff found Dr. Trachtenberg deviated from the standard of care by performing an endometrial ablation on P.C. without permission to do so. Dr. Trachtenberg stated that a short time before the surgery, P.C. called and said that she did not want the procedure performed. He claimed he was not made aware of this prior to the surgery and the nursing staff informed him there was no permit for the ablation just before the surgery. Dr. Trachtenberg stated that he proceeded with the procedure as his office notes indicated the patient did consent to it and he believed he was acting in the best interest of the patient. He hoped the Board would find that this did not rise to the level of discipline, as he has no prior Board history and has taken remedial action since to ensure that this does not happen again.

Dr. Martin led the questioning. Dr. Trachtenberg stated that he was concerned postoperatively P.C. would be upset that the ablation was not performed. He also stated that he did not see that the ablation was crossed off the consent form. One of Dr. Trachtenberg's staff wrote the note in the record indicating that P.C. would like to schedule a D&C only. Dr. Trachtenberg stated it did not seem important during the procedure that it was documented in the operative note. Dr. Martin noted that the nursing staff stopped him during the procedure to bring this to his attention, but he continued with the procedure. Dr. Martin noted an obvious miscommunication that led him to perform the procedure. Dr. Petelin stated that the communication problem seemed to be with his office staff. Dr. Petelin commented that Dr. Trachtenberg had it clear in his mind that he was going to perform the ablation and he was ready to do it. In closing, Mr. Lewis stated Dr. Trachtenberg has practiced in his community for over thirty years without any action that would mark his record or his reputation. While there is either a misunderstanding or miscommunication, he did nothing that the Board could find caused harm to the patient. Mr. Lewis asked that Board to resolve the matter with an Advisory Letter so that they can track Dr. Trachtenberg's performance to ensure that this does not occur again. Dr. Martin stated there was clear evidence in the chart that P.C. did not want the ablation to take place and noted this caused emotional harm to the patient.

MOTION: Dr. Martin moved for a finding of unprofessional conduct in violation of A.R.S. §32-1401 (27) (q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Dr. Mackstaller

Dr. Mackstaller stated that whether a procedure was or was not beneficial, the patient did not want it. Once a patient is under anesthesia, she depends on the surgeon to do what she requested.

VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

Dr. Martin commented that the physician was forthright in his testimony and demonstrated knowledge in this area and is current with the guidelines. Dr. Martin stated the procedure was done when the patient did not want it.

MOTION: Dr. Martin moved for a Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimamd for performing a procedure to which the patient did not consent.

SECONDED: Dr. Mackstaller

Dr. Petelin spoke in favor of the motion and stated that the office staff documented that Dr. Trachtenberg was notified of the patient's request. Dr. Mackstaller agreed and stated that when the nurses told him they did not have permission to perform the procedure, he elected to proceed anyway.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ms. Griffen, Dr. Mackstaller, Dr. Martin, and Dr. Petelin. The following Board Members voted against the motion: Dr. Goldfarb, Dr. Lefkowitz, and Dr. Pardo. The following Board Members were abstained: Dr. Lee and Ms. Proulx. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 4-yay, 3-nay, 2-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-06-0847A	M.K.	UNEN D. HSU, M.D.	8373	Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for inappropriate narcotic prescribing with a 15 year Probation restricting him from prescribing narcotics. The physician may petition the Board within 5 years for termination of the restriction. The Interim Consent Agreement will remain in effect until the effective date of this Order.

Dr. Hsu was present with counsel, Mr. James Taylor. Dr. Moczynski summarized the case for the Board. Staff found multiple deviations from the standard of care in Dr. Hsu's care and treatment patients with drug addictions. Dr. Hsu treated a patient for heroin addiction with methadone for two years in his office practice despite Federal and State guidelines expressly prohibiting such treatment except in a licensed opioid treatment center. In order to have the prescriptions filled Dr. Hsu falsified the prescription of methadone stating it was for the treatment of chronic pain and not for heroin addiction.. Dr. Hsu prescribed a combination of methadone and benzodiazepines with inadequate knowledge of the combined euphoric effect of these drugs which are more powerful and addicting than heroin. Dr. Hsu failed to provide even the most basic medical care for a patient with a history of intravenous (IV) drug abuse and he failed to test the patient for hepatitis or HIV and failed to recognize the signs of IV drug abuse. Dr. Hsu failed to maintain adequate records for prescriptions of methadone and benzodiazepines without chart documentation on a number of occasions. Dr. Hsu failed to closely monitor a patient for signs of non-compliance with her drug usage, and failed to recognize the patient required early prescriptions for lost or stolen prescriptions and was hospitalized at times for overuse. Dr. Hsu perpetuated the patient's addiction for two years by writing a prescription for methadone and benzodiazepines for a heroin addict and failed to adequately evaluate the patient prior to prescribing controlled substances. Further, Dr. Moczynski noted that Dr. Hsu violated his interim consent agreement with the Board in December 2006, which prohibited him from prescribing controlled substances by prescribing Soma, a class IV controlled substance.

Dr. Lee led the questioning. The Board reviewed Dr. Hsu's care and treatment for patient HM. HM had been kicked out of a methadone clinic and presented to Dr. Hsu for treatment of heroin addiction. Dr. Hsu prescribed HM Paxil when she threatened to kill herself with Xanax. Dr. Hsu stated he was trying to help his patients and trusted them to tell him the truth. Dr. Lee noted that trusting the patient is very important, but it should be supported by tests, treatment plans, consultations and histories. Dr. Hsu stated he would have done the same for any other patient. In another case, Dr. Hsu was prescribing narcotics to a patient without reviewing the patient's prior medical records. Dr. Hsu received this patient's medical record four months after initially prescribing the narcotics. In closing, Mr. Taylor stated that Dr. Hsu has tried to make it clear to the Board that he was not aware of the law with respect to prescribing methadone to heroin addicts. Mr. Taylor also stated that Dr. Hsu was trying to show the Board that he does recognize his mistakes. He asked the Board to consider Dr. Hsu's practice up to this point and that prescription writing is important to him in the care of his patients and asked the Board to consider not restricting Dr. Hsu's prescription writing privileges. Dr. Lee stated that this case was very difficult for him and that he could not understand Dr. Hsu's explanation for treating the patients the way he did.

MOTION: Dr. Lee moved for a finding of unprofessional conduct in violation of A.R.S. §32-1401 (27) (e)- Failing or refusing to maintain adequate records on a patient, A.R.S. §32-1401 (27)(j)- Prescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes, A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public, and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.

SECONDED: Dr. Petelin
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

Dr. Lee noted that the treatment plan for HM could have been lethal to her. Dr. Lee stated he believed that Dr. Hsu was ignoring the red flags and stated he would likely repeat such dangerous treatment plans. Dr. Lee commented that nothing Dr. Hsu testified to the Board made him comfortable that he fully understood the egregious nature of his practice with these patients. Dr. Lee

believed the restriction will benefit and protect the public. He stated that the Interim Consent Agreement should remain in effect until the effective date of this Order.

MOTION: Dr. Lee moved for a Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for inappropriate narcotic prescribing with a 10 year Probation restricting him from prescribing narcotics. The Interim Consent Agreement will remain in effect until the effective date of this Order.
SECONDED: Dr. Petelin

Dr. Martin spoke in favor of trying to find a way to help Dr. Hsu understand his mistakes and to help him remediate them to provide evidence of remediation to the Board. Dr. Martin suggested the Board require Dr. Hsu to obtain CME to help educate him in prescribing. Dr. Lee agreed. Staff informed the Board that there are courses available to address the Board's concerns. Ms. Cassetta informed the Board that they could word their motion to require Dr. Hsu to petition the Board for removal of the restriction after undergoing additional training or courses to help educate him or state that the restriction should remain in place for the entire probationary period.

AMENDED MOTION: Dr. Lee moved for a Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for inappropriate narcotic prescribing with a 15 year Probation restricting him from prescribing narcotics. The physician may petition the Board within 5 years for termination of the restriction. The Interim Consent Agreement will remain in effect until the effective date of this Order.
SECONDED: Dr. Petelin

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, and Ms. Proulx. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-06-0987A	AMB	THOMAS H. ON, M.D.	21605	Dismiss

Dr. On was present with counsel, Mr. Winn Sammons. Dr. Petelin stated that he knew Dr. On, but it would not affect his ability to adjudicate the case. Dr. Moczynski summarized the case for the Board. This case was brought to the attention of the Board as a result of a medical malpractice case settlement. Staff found Dr. On deviated from the standard of care by allowing compartment syndrome of the hand to occur. Staff noted Dr. On responded appropriately once the syndrome was recognized. Staff found it aggravating that the hand was covered and could not be observed during the procedure. Staff found it mitigating that he recognized the severity of the injury and arranged for an emergency hand consultation. Dr. On disagreed with the conclusion of the medical consultant. He stated the operating room was cold and the patient needed to be covered to prevent hypothermia which would interfere with the patient's well being. He stated that most practicing anesthesiologists do not specifically look for the IV site because it is not always practical or possible.

Dr. Lee led the questioning. Dr. On stated that this was the first time he had ever seen anything of this nature. Dr. Moczynski confirmed for the Board that it is unusual to develop compartment syndrome of subcutaneously infiltrated fluids. Dr. On explained that the modalities used were visualization of the drip chamber, the responsiveness of both the patient's response to the drugs as well as the responsiveness of the drip chamber as he had manipulated the dial flow. Dr. On stated he believed he acted appropriately once he ascertained that the IV had been infiltrated. Dr. Lee commented he was obligated to examine the IV site more closely. Dr. On stated he is now more cognizant of the IV site during procedures. Dr. Petelin noted that Dr. On did not start the IV on the patient, the nursing staff did. In closing, Mr. Sammons pointed out that the malpractice was settled due to the fact that the physician had a family member with health issues. Dr. Lee believed the standard of care for an anesthesiologist should assess the proper functioning of an IV during a procedure using various modalities. When the IV is not functioning properly, the physician is required to take appropriate corrective action. He believed Dr. On appropriately assessed the IV, but noted that the patient did undergo additional surgery. Dr. Lee commented that it is standard of care in an operating room setting to cover up many of the patient's body parts and stated he felt Dr. On met the standard of care in this case.

MOTION: Dr. Lee moved to dismiss the case.
SECONDED: Dr. Goldfarb
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, and Ms. Proulx. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

FORMAL HEARING MATTERS – CONSIDERATION OF ALJ RECOMMENDED DECISION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-07-0247A	AMB	MARVIN L. GIBBS, M.D.	13736	Revocation.

Dr. Gibbs was present with legal counsel, Mr. Daniel Jantsch. Anne Froedge, Assistant Attorney General, summarized the case for the Board. She stated that the Administrative Law Judge (ALJ) cited the correct law, but his statement was not correct in conclusions of law #3. She stated the findings of fact support the conclusions of law, but the wording should be consistent with the interim conclusions of law from the summary suspension order. She also stated that the ALJ cited A.R.S. §32-1401 (27)(A) instead of A.R.S. §32-3201(A), which provided that Dr. Gibbs shall not practice in this state until the investigation is completed. AAG Froedge stated that the State requests the Board uphold the summary suspension and revoke Dr. Gibbs' license to practice. Mr. Jantsch reminded the Board that their function is to ensure that Dr. Gibbs is given his right to exercise his due process of law. He stated it was clear that the ALJ did not understand what the term "dispense" means from a legal standpoint. He stated the ALJ made a finding that Dr. Gibbs was practicing medicine when there is no evidence that he was practicing at any time as he had two other physicians practicing for him. Mr. Jantsch did not believe Dr. Gibbs was being allowed his due process based upon the findings. He stated the dispensing was done prior to the suspension of his license. He also stated he did not believe Dr. Gibbs deserved to be revoked based on the evidence presented. He concluded it has to be proven by a preponderance of evidence that the allegations are supported by the evidence. AAG Froedge defined dispensing for the Board and stated that clearly the incident that occurred in March 2007 while Dr. Gibbs was on suspended status. She also stated it was critical that he practiced during the time that he was under the summary suspension. She stated the ALJ was correct with the exception previously noted.

MOTION: Dr. Lee Moved to accept the ALJ's recommended Findings of Fact.
SECONDED: Ms. Griffen
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

MOTION: Dr. Lee moved to accept the ALJ's recommended Conclusions of Law with modifications as recommended.
SECONDED: Dr. Petelin
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

MOTION: Dr. Goldfarb moved to accept the ALJ's recommended Order to Revoke Dr. Gibbs' license.
SECONDED: Dr. Petelin
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-00-0821 MD-04-0664A	J.G. AMB	MARVIN L. GIBBS, M.D.	13736	Rescind the referral to formal hearing, administratively close the cases and retain the investigative materials.

Mr. Dan Jantsch was present and spoke during the call to public on behalf of Dr. Gibbs. Mr. Jantsch stated that the first case involved an issue that arose at Mesa Lutheran Hospital and occurred a number of years ago. Dr. Gibbs appeared for a formal interview when the Board dismissed the quality of care issues, but issued a Letter of Reprimand based on the medical records violation. Mr. Jantsch claimed he and Dr. Gibbs never had a chance to address these issues. They filed a motion to the Board to re-review the case; however, the Board referred the case to formal hearing. This case has been pending a formal hearing for approximately four years. Mr. Jantsch noted the Board immediately referred the second case to formal hearing which has been pending a hearing for two years. Dr. Gibbs was also present and spoke during the call to public. He gave a brief overview of each case to the Board. He stated the allegations in both cases are either false or inaccurate. The Board noted that the previous action was to revoke Dr. Gibbs' license to practice and questioned how to handle this matter. Ms. Cassetta informed the Board that because of a recent court of appeals decision, the State does not have jurisdiction to proceed with these cases and therefore, the Attorney General's Office requested the Board rescind the referral to formal hearing. Anne Froedge, Assistant Attorney General, stated that since the license has been revoked, there is no longer a license to discipline. Staff explained to the Board that this would not be dismissing the cases and that if Dr. Gibbs should reapply after five years, the case materials would be retained, so that the Board may reconsider them at the time of his application for licensure.

MOTION: Dr. Goldfarb moved to rescind the referral to formal hearing, administratively close the cases and retain the investigative materials.
SECONDED: Dr. Mackstaller
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	RESOLUTION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-07-0126A	A.C.	LE ROI A. BAEZ, M.D.	30154	Modify the ALJ's recommended Order to lift the suspension and allow Dr. Baez to return to his practice requiring a chaperone with all female patients. Within 30 days, undergo a psychosexual evaluation at a board approved facility other than SRI and return that information to the Executive Director. If there are no recommendations for continuing monitoring, the ED can vacate the chaperone requirement. If there are recommendations, the physician will abide by those recommendations as approved by Board Staff.

Dr. Baez was present with legal counsel, Mr. Jantsch. AAG Froedge summarized the case for the Board. She stated that the findings are entirely appropriate in this case and are based upon substantial evidence. A.C. had been an employee of Dr. Baez and had seen him often in the hospital over the years. Ms. Froedge commented that it did not make sense that A.C. would make the allegations up as she promptly reported the matter to the police and to the Board. Ms. Froedge noted that A.C. fully cooperated during the course of the investigation and hearing. She stated ALJ was in the position to test the credibility of each witness who testified during the hearing. She informed the Board that at the hearing Dr. Baez first presented a check with the word "loan" on it. However, he later contacted his attorney admitting that he lied about the check and the wording on it. She opined that Dr. Baez perpetuated a lie. Ms. Froedge also informed the Board that the ALJ received evidence proving that the other employee arrived following the alleged incident and was not there at the time of the incident, as Dr. Baez alleged.

Mr. Jantsch addressed the Board and stated in no way did he condone the conduct of Dr. Baez falsifying the check. However, he stated Dr. Baez could have sat back and not said anything, but instead spoke up and set the record straight. He stated the other employee called for Dr. Baez to let her in the building because she had her hands full and did not want to dig around her purse for the keys. Mr. Jantsch stated it was interesting how Dr. Baez chose to assault A.C. in the hallway, as A.C. had alleged, if previously he had her alone in his office. He noted the hospital advised A.C. to report the incident to the police, she did not go to the police right away as claimed. He informed the Board that the physician that evaluated Dr. Baez admitted his conclusion was based on speculation. He concluded that anything other than finding Dr. Baez did not commit unprofessional conduct would be unjust. Ms. Froedge stated there is no documented evidence to indicate what time the other employee arrived at the office. It was the Judge's role to make the findings that he made regarding the time frame. Ms. Froedge reminded the Board that the other employee's paycheck was coming from Dr. Baez and that may have tainted her testimony. In regard to the allegation of the evaluating physician, Ms. Froedge stated he only evaluated Dr. Baez in terms of his safety to return to practice, but still walked away with serious concerns. She noted that at one point, Dr. Baez called the evaluating physician to tell him that he had more information for him; however, Dr. Baez changed his mind and canceled the appointment to return. She concluded that the State recommended the findings, conclusion and order from the ALJ be adopted.

MOTION: Dr. Goldfarb moved to go into executive session.
SECONDED: Dr. Lee
Vote: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

The Board went into Executive Session for legal advice at 6:53 p.m.
The Board returned to Open Session at 7:05 p.m.
No deliberations or discussions occurred during Executive Session.

MOTION: Dr. Goldfarb moved to accept the ALJ's recommended Findings of Fact.
SECONDED: Dr. Lee
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

MOTION: Dr. Lee moved to accept the ALJ's recommended Conclusions of Law.
SECONDED: Dr. Pardo
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

Dr. Goldfarb stated he was not comfortable with the recommended Order and requested modification be made.

MOTION: Dr. Goldfarb moved to modify the ALJ's recommended Order to lift the suspension and allow Dr. Baez to return to his practice requiring a chaperone with all female patients. Within 30 days, undergo a psychosexual evaluation at a board approved facility other than SRI and return that information to the Executive Director. If there are no recommendations for continuing monitoring, the ED can vacate the chaperone requirement. If there are findings, the physician will abide by those recommendations as approved by Board Staff.

SECONDED: Dr. Mackstaller
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

After voting, Mr. Miller asked the Board to revisit this case for one additional step. Ms. Cassetta informed the Board that they would need to make this action immediately effective if they intend to have Dr. Baez return to practice immediately. She asked that the summary suspension remain in effect until Staff can issue the Order to Dr. Baez.

MOTION: Dr. Goldfarb moved to make a Finding of immediate effectiveness on the grounds that rehearing is in contrary to public interest.
SECONDED: Ms. Griffen
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-07-0309A	AMB	THOMAS J. GRADE, M.D.	10424	Revocation.

Dr. Grade was not present during the consideration of this matter. Mr. Brekke summarized the case for the Board. Dr. Grade failed to cooperate with the Board during the investigation and failed to appear at the formal hearing. Dr. Grade retained an attorney who contacted Mr. Brekke the day before the hearing and asked for a continuance, which the judge denied. Dr. Grade declined a proposed consent agreement for surrender of his license provided by Staff. The ALJ moved forward with the hearing. Mr. Brekke stated the sanction in the revocation of his license is warranted and asked that the Board adopt the decision by the ALJ. Ms. Cassetta stated that the Order was missing the statements of jurisdiction and contained the physician's, as well as his wife's home address and she felt it was inappropriate and suggested using the wording "address of record" or "the wife's home".

MOTION: Dr. Lee moved to accept the ALJ's recommended Findings of Fact as modified.
SECONDED: Dr. Petelin
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

MOTION: Dr. Pardo moved to accept the ALJ's recommended Conclusions of Law.
SECONDED: Dr. Mackstaller
VOTE: 9-yay, 0-nay, 0-abstian, 0-recuse, 3-absent.
MOTION PASSED.

MOTION: Dr. Mackstaller moved to accept the ALJ's recommended Order to Revoke Dr. Grade's license.
SECONDED: Ms. Griffen
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-04-0540A MD-05-0253A MD-05-1165A	AMB A.M. R.M.	THOMAS J. GRADE, M.D.	10424	Rescind the referral to formal hearing, administratively close the cases, and retain the investigative materials.

The above listed cases were referred to the Attorney General's Office with a referral to formal hearing. Mr. Brekke stated he felt it was appropriate for the Board to rescind the referral to formal hearing for these cases as the State no longer held jurisdiction over the physician's license.

MOTION: Dr. Lee moved to rescind the referral to formal hearing, administratively close the cases and retain the investigative materials
SECONDED: Dr. Pardo
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

Thursday, August 9, 2007

Call to Order
The meeting was called to order at 8:00 a.m.

Roll Call
The following Board Members were present: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members were not present: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.

Call to Public
Statements issued during the call to public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
1.	MD-06-0554A	AMB	CESAR VILLARREAL, M.D.	30915	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for committing a misdemeanor involving moral turpitude.

Dr. Villarreal was present without counsel. Celina Shepherd, Case Manager, summarized the case for the Board. Dr. Villarreal was arrested in New Mexico (NM) and charged for patronizing a prostitute. He entered into a plea bargain and the charges were eventually dismissed because the arresting officer's witness was not available to appear in court. Staff found Dr. Villarreal admitted to the acts and there is sufficient evidence to sustain a violation of A.R.S. §32-1401 (27)(d). Dr. Villarreal stated he was not patronizing a prostitute and the case was dismissed in April of 2007. Ms. Griffen led the questioning. She noted Dr. Villarreal has no prior Board history. Dr. Villarreal claimed he was in NM with his wife for a doctor's appointment. He stated he was out looking for the physician's office on the night of the arrest. He stopped to ask a woman for directions who told him she was going that same way and would show him where he needed to go. Dr. Villarreal agreed and returned to his hotel to pick up his wife for dinner and stated the woman went on her way. However, when he got out of his car the officers detained him. Dr. Villarreal expressed to the Board that he did not know why he was arrested and stated the charges were dropped because there was no evidence.

MOTION: Dr. Goldfarb moved to go into executive session.
SECONDED: Dr. Lee
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

The Board went into Executive Session for legal advice at 8:18 a.m.
The Board returned to Open Session at 8:22 a.m.
No deliberations or discussions occurred during Executive Session.

Dr. Villarreal confirmed that the vehicle described in the police report was his. However, Dr. Villarreal stated the information in the police report was inaccurate. Dr. Martin stated that the only thing that physicians have is their reputations and honor. He did not believe Dr. Villarreal's testimony. He noted Dr. Villarreal admitted the woman was in his car, but the Board does not know what happened during that time. Ms. Shepherd informed the Board that this is the first Staff has heard that Dr. Villarreal was out that night looking for a physician's office. Ms. Griffen stated this is a case of unprofessional conduct and there is a preponderance of evidence to support the violation.

MOTION: Ms. Griffen moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27) (d) - Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by any court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission.
SECONDED: Dr. Petelin

VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

Ms. Griffen stated that she was confused by Dr. Villarreal's testimony, but did believe that there was an occurrence that night that is different from Dr. Villarreal's explanation. Ms. Griffen opined that it was not a smart thing to nor was it smart for him to appear before the Board and try to make them think otherwise.

MOTION: Ms. Griffen moved for a Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for committing a misdemeanor involving moral turpitude.
SECONDED: Dr. Mackstaller

Dr. Goldfarb commented it would be unusual to come from out of town for a doctor's appointment in the evening. Dr. Mackstaller stated she supported the Letter of Reprimand. Dr. Martin stated a physician's profession is based upon honesty and integrity. Dr. Martin also spoke in favor of the motion. He stated that for Dr. Villarreal to come to an interview and expect the Board to accept anything less than honesty and integrity is a poor decision on his part.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
2.	MD-06-0367A	N.B.	DAVID A. PEDERSEN, M.D.	23255	Issue an Advisory Letter for failure to adequately document examinations and for failure to timely examine a patient post-operatively. This does not rise to the level of discipline.

David Tallman was present and spoke during the call to public on behalf of Dr. Pedersen. Mr. Tallman is a physician assistant (PA) who works with Dr. Pedersen. He reviewed this case and was satisfied that their pattern of close communication was carried out. He would not work in a less responsible relationship. N.B. was also present and spoke prior to Dr. Pedersen's interview. She stated the deceased patient was her father. She stated Dr. Pedersen delegated his duties to his PA and failed to follow up on the patient while in the intensive care unit. Dr. Pedersen went out of town and did not return the family's phone calls. She stated that all physicians should be much more mindful of their patients. She did not want another family to have to endure what her family did in this case. Dr. Pedersen was present with counsel, Mr. Paul Giancola. Dr. Martin stated he knew Mr. Giancola, but it would not affect his ability to adjudicate the case. Dr. Mackstaller stated she knew both Dr. Pedersen and PA Tallman, but it would not affect her ability to adjudicate the case. Dr. Wolf summarized the case for the Board. Staff found Dr. Pedersen deviated from the standard of care by failing to see the patient personally in a timely manner when the patient developed postoperative abdominal distension. Dr. Pedersen stated that several surgeons use PAs in all office settings. In this case, his communication system with his PA did not break down. Dr. Pedersen realized he let down the family of the patient and stated he took it to heart and has since changed his practice.

Dr. Petelin led the questioning. He noted the issue is whether Dr. Pedersen provided adequate postoperative care. Dr. Pedersen stated that having the PA monitor the patient postoperatively was not excluded in the hospital's bylaws. He stated he had contact with his PA daily and that they would cross paths numerous times. If Dr. Pedersen did not hear from the PA by the middle of the day, they would meet over the lunch hour to discuss cases. He stated that during the time of this patient's care he had others to care for as well. Dr. Petelin noted Dr. Pedersen only saw the patient twice in seven days and stated the patient deserved to be followed more closely by Dr. Pedersen. Dr. Petelin stated he could not tell if Dr. Pedersen was actually present or if he only countersigned the patient's chart. All that Dr. Pedersen signed was the chart with no extra notes indicating why he signed it. Dr. Pedersen stated he reviews the PA's charts to ensure a thorough examination was conducted. Dr. Pedersen informed the Board that he did not recollect the patient's family constantly calling him as alleged. He stated he either did not receive the calls or they were not logged in by his office staff. Dr. Goldfarb noted PA Tallman was very experienced and seemed to be very good at what he does. He stated he understands that physicians use physician extenders and that they rely more and more on them. Dr. Pedersen informed the Board that he has given up his practices at other locations to give more of his time to his own practice. He also stated that he is fearful that the volume of patients will continue to increase and he would eventually have to turn patients down. Dr. Lefkowitz opined that even with an extremely well trained PA, the ultimate responsibility lies on the surgeon for his patients. Dr. Pedersen stated that PA Tallman has a great track record of informing him when he needs to come in to see a patient.

In closing, Mr. Giancola stated it should be clear to the Board that Dr. Pedersen is a very caring, meticulous, and busy surgeon and in looking at the standard practice in Arizona, he exceeds it. He stated the key part is that the responsible physician must assess the scope of practice and training of the PA to make sure that the duties that are delegated are properly done. He concluded that the results would have been the same had Dr. Pedersen seen this patient personally. Dr. Petelin stated he did not feel this case rises to the level of discipline. He noted Dr. Pedersen failed to document when the patient was seen by him and signed the chart, but does not indicate that the patient was seen by him.

MOTION: Dr. Petelin moved to issue the physician an Advisory Letter for failure to adequately document examinations and for failure to timely examine a patient post-operatively. This does not rise to the level of discipline.
SECONDED: Dr. Mackstaller

Dr. Petelin noted deficiencies in the medical records. He believed that once the patient started to have problems with distension, Dr. Pedersen should have seen the patient on a daily basis and assessed the patient himself starting on postoperative day four when the abdomen was noted to be markedly distended. He stated this conduct had the potential for being harmful or dangerous. Dr. Goldfarb spoke in support of the motion. Dr. Martin stated it was not clear to him from the testimony exactly how much Dr. Pedersen did know about the postoperative care and how much was communicated to him from the PA. Dr. Mackstaller agreed

with Dr. Martin. Dr. Martin wondered if the PA should be referred to the Arizona Regulatory Board of Physician Assistants. Both Drs. Goldfarb and Petelin did not believe supervising the PA was an issue. Dr. Petelin stated he felt the supervision was adequate but, Dr. Pedersen should have been more personally involved. Dr. Pardo commented that the PA was responsible for making certain decisions. She opined that there is no point of using physician extenders if the physician has to essentially do everything anyway. The Board did not agree to refer the PA to the Arizona Regulatory Board of Physician Assistants.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
3.	MD-06-0456A	BANNER MEDICAL CENTER	MICHAEL R. ROLLINS, M.D.	30379	Continue the interview, re-notice the physician on the additional issue, and bring the matter back to the Board.

Dr. Rollins was present with counsel, Mr. Stephen W. Meyers. Dr. Wolf summarized the case for the Board. Staff found Dr. Rollins deviated from the standard of care by failing to timely operate on a patient with postoperative complications. Dr. Rollins stated that in retrospect, he wished he had taken the patient back to the operating room immediately. He did not expect this patient to decline as rapidly as he did. Dr. Rollins informed the Board he has taken a more aggressive approach surgically in any patient who now presents in any way similar to this patient. Dr. Rollins apologized to the family and friends of J.H. for the outcome of his care.

MOTION: Dr. Mackstaller moved to go into executive session.
SECONDED: Dr. Lee
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

The Board went into Executive Session for legal advice at 10:22 a.m.
The Board returned to Open Session at 10:27 a.m.
No deliberations or discussions occurred during Executive Session.

Dr. Mackstaller stated her concern with this case was not that Dr. Rollin's did not operate in a timely fashion postoperatively. She stated she was concerned with the anemia and hemorrhage that the patient experienced during the first surgery. She stated that had this been addressed, the patient might not have died. Mr. Myers stated Dr. Rollins was not prepared to go forward with the case as Dr. Mackstaller's concerns were not part of the malpractice case and they were not noticed on this issue prior to the interview. Dr. Mackstaller stated she felt very strongly that the reason the patient died was due to the hemorrhage that was not diagnosed in a timely fashion. She commented that the patient might have survived had that been addressed and treated aggressively. Dr. Mackstaller thought the Board has an obligation to look into the patient's possible cause of death rather than just reviewing the malpractice case. Ms. Cassetta informed the Board that they may suspend the interview to allow Staff to re-notice Dr. Rollins with Dr. Mackstaller's concerns and allow him the opportunity to respond to the additional allegation.

MOTION: Dr. Mackstaller moved to continue the interview, re-notice the physician on the additional issue, and bring the matter back to the Board.
SECONDED: Dr. Petelin
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
4.	MD-06-0014A	V.C.	ROBERT A. CAMPBELL, M.D.	32900	Issue an Advisory Letter for failure to timely diagnose and treat an acute colonic perforated bowel and for inadequate medical records. This does not rise to the level of discipline.

Dr. Campbell was present with counsel, Mr. Robert J. Milligan. Drs. Goldfarb and Martin stated they knew Mr. Milligan, but it would not affect their ability to adjudicate the case. Dr. Wolf summarized the case for the Board. Staff found Dr. Campbell deviated from the standard of care by failing to operate on HP in a timely fashion. Staff found it mitigating that he followed the patient carefully prior to surgery. Staff also found it mitigating that the patient was in the high risk group by the nature of his disease and that the three-day delay allowed further preoperative cardiac evaluation in a smoker with known coronary artery disease. Staff found it aggravating that the delay was unlikely to have made a difference between life and death. Dr. Campbell stated the timing of the surgery was to allow for a complete work up the patient. He stated the removal of the patient's rectum was justified based on the clinical appearance of the rectum and the known findings on a flexible sigmoidoscopy. The operative dictation was performed later due to an oversight by Dr. Campbell. Dr. Campbell stated his actions did not negatively impact the patient's outcome and requested the Board dismiss this case. Dr. Petelin led the questioning. Dr. Petelin found no reason in the patient records for the delay in surgery. Dr. Campbell stated he did not approach this patient lightly and that this was a complex case from the beginning. Dr. Campbell stated he knew the patient would end up in the operating room eventually because the patient was not making any

significant progress. Dr. Petelin stated he understood that Dr. Campbell's enthusiasm to operate on this patient was not great; however, this did not justify the four day delay.

Dr. Campbell informed the Board that Banner Health's policy requires a dictated report no later than 24 hours after a procedure is performed. Dr. Campbell made a handwritten note in the patient's chart immediately after the procedure, but dictated the operative report three weeks after the procedure was performed. Dr. Petelin noted some discrepancies in the two different entries regarding the procedure. Dr. Campbell stated he knew this would be called into question eventually. Dr. Petelin stated that an operative report tends to lose its credibility the later it is dictated. Dr. Goldfarb commented that he had never seen such an elaborate note that late after surgery. Dr. Campbell stated that the handwritten note was not as accurate, since it was done sooner. He stated the case was still very vivid in his mind three weeks later. If he could go back, Dr. Campbell stated he would have operated sooner. In closing, Mr. Milligan stated that every reviewer of this case could agree that this was a complex case. He noted the the surgery may have triggered the surge that caused the patient's death. He concluded this case involved a lot of different issues and a lot of different opinions. Dr. Campbell stated this case came down to a judgment call. He stated the patient was heading towards surgery and was not getting better. He stated he would never try to mislead anyone even in the tardiness of a dictation. He stated the patient's death was due to the surgery, but the surgery was unavoidable. Dr. Petelin noted there was free air in the patient's abdomen and free air only comes from a perforation. He stated this was a sick patient who waited four days and that could not have been beneficial. Dr. Petelin stated it did not seem to him that Dr. Campbell had gained any additional experience from his management of this patient.

MOTION: Dr. Petelin moved to issue the physician an Advisory Letter for failure to timely diagnose and failure to treat an acute colonic perforated bowel and for inadequate medical records. This does not rise to the level of discipline.
SECONDED: Dr. Lefkowitz

Dr. Lee wondered why Dr. Campbell was not cited with a violation of A.R.S. §32-1401 (27)(t). Staff clarified why they believed the Board could not sustain this violation. Dr. Mackstaller stated she knows a lot of times there are reasons to hold off on surgery. She spoke against the motion and suggested dismissal. Dr. Petelin stated the patient's outcome is unknown, had the surgery been performed earlier. However, Dr. Petelin said there was no advantage to be gained by a delay of surgery.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Pardo, and Dr. Petelin. The following Board Members voted against the motion: Dr. Mackstaller. The following Board Members abstained: Dr. Martin and Ms. Proulx. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 6-yay, 1-nay, 2-abstain, 0-recuse, 3-absent.
MOTION PASSED.

Call to Public
Statements issued during the call to public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
5.	MD-06-0924A	AMB	MAX D. LIND, M.D.	4576	Issue an Advisory Letter for failure to remove IUD at the time of bilateral tubal ligation resulting in a second surgical procedure to remove the IUD. This was a one time technical violation.

Dr. Lind was present without counsel. Dr. Petelin recused himself from the case. Ingrid Haas, M.D., Medical Consultant, summarized the case for the Board. Staff found Dr. Lind deviated from the standard of care by failing to remove an intrauterine device (IUD). Dr. Lind agreed that the IUD should have been removed. He stated that he would normally schedule the removal of the IUD when scheduling a tubal ligation, but this was not done. He stated he absolutely forgot the IUD was still in. He concluded by stating that there was no question that he was negligent in not removing the IUD, but it was unintentional. Dr. Martin led the questioning. Dr. Lind is not currently practicing and has been retired for three years. Dr. Lind confirmed that IUDs should not stay in place for more than ten years and explained to the Board the purpose for an IUD. Dr. Martin noted Dr. Lind readily admitted that the IUD was inserted by him and during the sterilization process for the tubal ligation, it should have been removed, but was not. Dr. Martin wondered if the public was served by the Board taking disciplinary action against Dr. Lind's medical license since he has been retired for many years.

MOTION: Dr. Martin moved to issue the physician an Advisory Letter for failure to remove IUD at the time of bilateral tubal ligation resulting in a second surgical procedure to remove the IUD. This was a one time technical violation.
SECONDED: Dr. Mackstaller
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, and Ms. Proulx. The following Board Members

were recused from this case: Dr. Petelin. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 8-yay, 0-nay, 0-abstain, 1-recuse, 3-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
6.	MD-06-1043A	P.A.	DAVID L. GREENE, M.D.	32747	Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for multiple mishandled surgical complications and poor clinical judgment. Two Year Probation to include random chart reviews to include a prepared surgical case log including the number of cases, types of cases, and any complications. The physician must notify the hospitals where he is on staff to immediately report those complications to the board. The Order is effective immediately.

Dr. A. Joshua Appel was present and spoke during the call to public on behalf of Dr. Greene. He stated his practice hired Dr. Greene knowing he would be an asset to their practice as he has excellent judgment with regard to spine surgery. He stated everything Dr. Greene does is literature based and when a case is handled in their practice, multiple physicians are involved. To date, he stated that he and Dr. Greene have done about 85 cases together involving complex reconstructive spine thoracic lumbar cases. P.A. was also present and spoke just before the interview. She stated the first thing they did was check the Board's web site to see if there was anything against Dr. Greene's license and found nothing. She stated her mother did not know she was not an appropriate candidate for the surgery she underwent with Dr. Greene. She asked the Board to take the appropriate steps to protect the public to provide them the opportunity to make a well informed decision. Dr. Greene was present with counsel, Mr. Giancola. Dr. Martin stated he knew both Mr. Giancola and Dr. Greene, but it would not affect his ability to adjudicate the case.

MOTION: Dr. Goldfarb moved to accept the Motion for Good Cause submitted by the physician prior to the interview.
SECONDED: Dr. Mackstaller
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

Dr. Moczynski summarized the case for the Board. The index case involved patient L.O. and took place in January of 2006. L.O. deid on the operating table as Dr. Greene was performing surgery. Based on this case, Board Staff conducted a review of five other patient charts and found that patient P.H. died two days postoperatively in December 2005 from a laceration of the aorta. Patient R.D. was left with pain in the opposite leg and a foot drop postoperatively in February of 2005. Patient J.D. was paraplegic on awakening from surgery performed by Dr. Greene in July of 2005. Patient G.G. subsequently had an infection and needed multiple surgeries. Patient D.B. subsequently required intubation and drainage of a cervical hematoma shortly after surgery. Staff found these cases demonstrated Dr. Greene's poor surgical judgment and poor surgical technique.

Dr. Greene stated that he recognizes he is a young surgeon who has encountered several adverse events in his initial year of practice, but in over 550 cases, his technical complication rate is under one percent. He believed the Board would find that he is well trained, caring, thoughtful, and competent. He stated he has learned to be more selective in accepting patients for surgery and more proactive in postoperative assessments. He informed the Board that over the last year and a half, he has not had any major complications. Dr. Goldfarb led the questioning. Dr. Greene stated that in P.H.'s case, he saw her and her daughter for the first time on the day of the surgery and were all in agreement that surgery would be the best course of action. P.H. had been bed ridden and her quality of life had been severely diminished. Dr. Greene initially sent P.H. home right after seeing her as the hospital had no available beds. Dr. Goldfarb noted this was not an emergent surgery for P.H. Dr. Greene stated the hospital called that same night and told him that they had a bed available and he called P.H. to inform her and she decided to go through with surgery that night. Throughout the operation Dr. Greene had no idea things were not going well. P.H. was admitted to the intensive care unit as her systolic blood pressure was well over 100. Dr. Greene did not see P.H. until postoperative day three in which he was concerned she was having some sort of cardiac event. Dr. Goldfarb stated Dr. Greene should have spent more time getting to know the patient and should have been more conservative in her care. Dr. Greene stated this was a decision that they both made together.

Dr. Greene stated he tried many types of conservative treatment with R.D. including physical therapy, epidural injections and pharmacological treatments, but all had failed. R.D. woke up from surgery with pain in his right calf. Dr. Goldfarb noted R.D. presented with pain in his left side and did not have pain in his right calf prior to surgery. A CT scan was done about four or five days after surgery and Dr. Greene explained to the patient it was discovered that a screw had malpositioned and thought it would be best to either remove it or reposition it. R.D. left Dr. Greene's practice with a permanent foot drop.

Post operatively, J.D. had no sensation below the T9 spinal level. Dr. Goldfarb wondered why Dr. Greene elected to perform a kyphoplasty on a patient with a mild wedge compression that was three or four years old. G.G. presented to Dr. Greene with a working spinal cord stimulator and needed to have the battery changed. Dr. Greene stated that when he took the battery pack out, he slightly moved the pocket of the battery pack to try to avoid infection. Postoperatively, Dr. Greene noted G.G. was sitting on or

close to the area where the battery pocket had been created. Dr. Greene wanted to take him back to surgery to relocate it where it would be free of pressure and G.G. agreed. Dr. Moczynski noted there is indication in the record of a culture; however, the Board did not have the results and Dr. Greene could not recall. A couple of months following the surgery, G.G. sustained an infection in the new location of the battery pocket.

Dr. Greene performed three different procedures on L.O. During the third surgery, when he was using shavers to remove disc material, the anesthesiologist notified him that she was starting to lose her blood pressure. Dr. Greene removed a few screws, closed the wound and then turned her over to resuscitate. He stated she regained her pulse as he performed cardiopulmonary resuscitation. Dr. Mackstaller noted L.O. was screened by a cardiologist prior to the surgery. Dr. Greene was not sure if he reviewed her cardiology report prior to surgery. He stated he is not a cardiologist and relied on the cardiologist to advise him if she was a low, medium or high risk for that particular surgery. L.O. died seventy hours postoperatively.

Dr. Lee noted that a significant loss of blood during P.H.'s surgery. Dr. Greene stated this was an example of why he regularly ordered hemoglobin on these types of patients. Dr. Greene dictated his operative report after P.H. died. He did not believe it was important to dictate the report immediately postoperatively. Dr. Greene informed the Board that he involves another physician in each case and stated he also involves a pulmonary vascular physician, when necessary. Dr. Greene stated he no longer performs the same version of surgery as performed on J.D. He stated in retrospect, he would have removed G.G.'s stimulator entirely or used a new one in a different site. He commented the surgical indication was clear in P.H.'s case. In retrospect, Dr. Greene stated he should have obtained more consults in each case. Dr. Martin wondered what Dr. Greene would do differently intraoperatively. Dr. Greene stated he did not believe that he did anything intraoperatively to harm the patients. Dr. Martin commented it is the Board's job to protect the public and stated that from his testimony, Dr. Greene has not been able to show the Board that he understands the mistakes made intraoperatively. Dr. Greene stated he is very caring, extremely considerate, and conservative in his pre and postoperative care and his intraoperative technique. In closing, Mr. Giancola stated that everyone would agree that these are very complex cases. He referred to the adverse events as "hiccups" and not a predictor for Dr. Greene's practice in the future. He assured the Board that Dr. Greene is practicing competently, appropriately, and within the standard of care. He has learned from these cases and will take it with him as he moves forward so that the Board can see he will be practicing appropriately.

MOTION: Dr. Martin moved to go into executive session.
SECONDED: Dr. Mackstaller
Vote: 9-yay, 0-nay, 0-abstain, 3-recuse.
MOTION PASSED.

The Board went into Executive Session for legal advice at 3:46 p.m.
The Board returned to Open Session at 3:55 p.m.
No deliberations or discussions occurred during Executive Session.

Dr. Goldfarb commented that in the few years he has spent on the Board, it is unusual to see a number of cases such as these in such a short period of time. He informed the Board that any of these complications could happen to even a highly skilled surgeon. He stated each surgeon learns each day of his/her life and; hopefully, Dr. Greene has learned by the number of cases that he has done over this period of time. He stated Dr. Greene is in a situation now where he can obtain the guidance and the mentoring that is necessary to become successful physician.

MOTION: Dr. Goldfarb moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27) (q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public, A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Dr. Mackstaller

Dr. Goldfarb stated Dr. Greene failed to appropriately deal with surgical complications, displayed poor clinical judgment and selection of patients for surgery, and was overly aggressive in surgical treatment resulting in significant neurologic and vascular injuries. Dr. Petelin noted Staff also recommended the Board find Dr. Greene in violation of A.R.S. §32-1401 (27)(t) and wondered why Dr. Goldfarb did not include this in his motion. He stated Dr. Greene listed on the discharge summary that the cause of death was myocardial infarction when the autopsy listed it as laceration to the aorta. Dr. Goldfarb did not believe Dr. Greene intended to fraudulently dictate that record.

VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

MOTION: Dr. Goldfarb moved for a Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for multiple mishandled surgical complications and poor clinical judgment. Two Year Probation to include random chart

reviews to include a prepared surgical case log including the number of cases, types of cases, and any complications. The physician must notify the hospitals where he is on staff to immediately report those complications to the board.
SECONDED: Dr. Petelin

Dr. Martin spoke against the motion and stated he was not comfortable with Dr. Goldfarb's assessment. Dr. Goldfarb stated he came up with his recommendation on the basis that as far as the Board knows, Dr. Greene has not had any major complications within the past year. Dr. Petelin spoke in favor of the motion and stated he believed it was important to note that he has already been performing a fairly high volume of spinal surgery. He stated the motion was good in that it is restrictive and the Board can monitor him closely. He believed the motion was serving the purpose of protecting the public. Dr. Mackstaller spoke in favor of the motion and believed Dr. Greene needs to be supervised but thought he deserved a chance to continue practicing. Dr. Lee wondered if the Board felt more education would help the physician. Dr. Goldfarb stated any and all of the complications that were looked at are possible, even with a very skilled surgeon.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Petelin, Dr. Pardo, and Ms. Proulx. The following Board Members voted against the motion: Dr. Martin. The following Board Members were absent: Mr. Eckstrom, Dr. Krishna, and Dr. Schneider.
VOTE: 8-yay, 1-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

Ms. Cassetta stated that if the Board wished this to take effect immediately, they would need to vote on a finding of immediate effectiveness.

MOTION: Dr. Goldfarb moved to make this action immediately effective.
SECONDED: Ms. Proulx
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent.
MOTION PASSED.

The meeting was adjourned at 5:50 p.m.

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Timothy C. Miller, J.D. Executive Director